REHABILITATION RECORD

JANUARY AND FEBRUARY 1973

The Mid-Iowa Drug Abuse Council serves a half-million residents in Central Iowa with a variety of alternative drug education, prevention, and rehabilitation programs.

See page one.

Secretary Richardson On Allied Services Act, page 7.

Call To Arms

Louis Y. Nau, Ph. D.

The Rehabilitation Services Administration (RSA) has been providing vocational rehabilitation services to drug abusers in ever growing numbers since the mid-1960's. Since then, more than 5,000 persons successfully have been returned to productive participation in employment and society through the application of the rehabilitation process.

Concurrently the drug problem in America has grown to epidemic proportions. To meet and challenge this growth, a variety of programs and services have been initiated by government agencies, but a diffusion of efforts resulted. In 1970, the Special Action Office for Drug Abuse Prevention was created within the office of the President to provide leadership and to better coordinate and utilize government programs.

The Secretary of HEW, Elliot Richardson, has likewise taken decisive action which has brought the efforts of his Department into sharper focus on drug abuse treatment and rehabilitation. Two of these actions have had direct impact on the work of RSA.

First, a Special Assistant to the Secretary, Mr. Wade Coleman, has been appointed to coordinate drug abuse programs within HEW. Through his office the objectives, programs, and activities of all HEW agencies and bureaus, particularly RSA, are being brought together as a single departmental thrust. With such directed effort maximum utilization of Departmental resources can be assured.

Second, at the direction of the Secretary, a unique agreement for the integration of vocational rehabilitation services and drug abuse treatment services has been negotiated and signed between the RSA and the National Institute of Mental Health (NIMH). This agreement, together with the establishment of joint program objectives, provides the mechanism whereby comprehensive services, from application through evaluation, treatment, training, placement, and follow-along can be provided to drug abusers.

Dr. Edward Newman, RSA Commissioner, said at the signing ceremonies in San Juan, Puerto Rico, that the agreement is "the first step to establishing the proper mix of services to assure necessary and improved services to drug abuse clients." Dr. Bertram Brown, NIMH Director also commented on the agreement in the following words: "This is the first time that such a plan for intraagency cooperation and facility collaboration has been developed. This cooperative use of resources promises to have significant benefit for the success of drug abuse rehabilitation efforts."

The functional arrangements resulting from the RSA/NIMH agreement will be developed in each State between the State rehabilitation agency and the State mental health agency, and will promote cooperative participation in the provision of services, referrals, and resources.

The concept and practice of joint working relationships between rehabilitation and mental health is not new in the drug abuse treatment and rehabilitation process. The MIDAC program in Des Moines, Iowa (see article in this issue), operates as a result of a joint service and funding approach. The Stop 15 Drug Abuse Rehabilitation Center in San Juan, Puerto Rico, is prototypic of the kind of innovative working arrangements which this approach can foster. Many other such joint projects are currently being developed.

As the Nation strives to reduce and eliminate the problem of drug abuse and its handicapping effects to employment and social participation, it is necessary for all concerned persons and institutions to pool resources, harmonize activities and coordinate programs to assure success. The crisis we face warrants a "call to arms"' in the fight against this insidious foe.

Through its legislative mandate and commitment to the physically and mentally disabled and through its joint services and funding program with NIMH and other agencies, RSA is heeding the "call to arms." We invite you as coworkers in the field of rehabilitation to join with us in the forefront of this battle. ■

Dr. Nau is Special Assistant to the Commissioner, Rehabilitation Services Administration.

ALTERNATIVES

Theme of MIDAC Drug Programing

Charles W. Day, Ph. D.

With more than 18,000 youth on hand for the summer's biggest outdoor rock concert, many folks feared an outbreak of drug reactions, militant protests or youth-police confrontations. But the concert was largely a peaceful success. One reason was the visible presence of the Mid-Iowa Drug Abuse Council (MIDAC). We try to *relate to people on their terms and turfs,* and so we were there with staff, equipment, supplies, and vehicles to provide whatever emergency medical, counseling, and crisis intervention services might be needed.

Fortunately, only 33 persons required individual attention, most for heat prostration, some for first aid, and two for bad drug experiences. Many were "on drugs," but just two needed us. One was Peter, who wanted to play his guitar alongside the top performer. As he proceeded to the stage, he attracted the attention of police along with several hundred of his fellow youth nearby who made it fairly clear they did not want their compatriot arrested.

Dr. Day is a clinical psychologist and a student of law at the University of Washington. When the article was written he was executive director of the program he describes here.

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Because of continuing cooperation and communication between MIDAC and local law enforcement agencies, however, Peter was released to one of our counselors while another counselor carefully explained the situation to the 700 youth who had followed the police and Peter to the MIDAC shelter.

The importance of this incident should not be minimized. A single youth was spared having legal difficulties added to his existing burden of emotional and drug problems. Youth and police experienced cooperation rather than confrontation in the handling of a mutually unpleasant situation. And our efforts to *cultivate and maintain good communication and cooperation with law enforcement personnel* once again paid off.

MIDAC began in early 1970 and is currently a half-million dollar a year program serving a half-million residents in central Iowa with a variety of alternative drug education, prevention, and rehabilitation programs. About two-thirds of the population are in Greater Des Moines. Nearly one-fifth fall into the peak drug abusing age group of 15–24. No one is certain how many abuse drugs, but estimates based on police and treatment agency data indicate there are somewhere between 500 and 1,500 heroin addicts and countless thousands of school youngsters who have tried hallucinogens.

Free Medical Clinic

Medical staff covered the rock concert. Besides such on-the-spot coverage of youth events, they are on call 24 hours daily for drug overdoses and other medical emergencies, provide first aid training for drug counselors throughout central Iowa, and organize drug and related medical education programs for clients, health services, and other community agencies. Their primary function, however, is to operate the only free medical clinic in central Iowa. To do all this, they *utilize the skills of professional and paraprofessional volunteers and qualified students in job training and educational institutions.*

The clinic serves about 200 clients a month. The typical patient is 20 years old, female (54 percent), white (84 percent), with a complaint related to drug abuse (19 percent), gynecology (18 percent), the eyes, ears, nose, or throat (19 percent), or venereal disease (6 percent). With the needs too great, the dollars too few, and the expertise too limited in the area of drug abuse and rehabilitation, MIDAC tries to *avoid duplicating services by establishing working relationships with other community health and supportive service agencies.* For example, we have cooperative medical arrangements with local hospital emergency rooms, outpatient and inpatient psychiatric resources, and family planning agencies to provide services for our clients.

"Disappointments often have been minimized, fears allayed, and criticisms forestalled by our willingness to inform community and clients alike of the high failure risks which are involved in drug rehabilitation today."

Several studies have also been done to assure that the clinic itself does not violate our objective of avoiding duplication. A subcommittee study by the local Health Planning Council concluded that MIDAC medical services were provided at times when other clinics were closed to clients who, in any case, often resisted or refused to seek or follow through with medical help from these agencies.

A poll of our own clients confirmed that nearly 30 percent of them might not have sought medical attention if our clinic had not been available. Finally, the city health department, with whom we cooperate in treatment and education concerning venereal disease, has reported that many VD contacts who refuse to report to the health department for tests will come to our clinic.

MIDAC tries to *design services which meet the needs of the particular clients to be served.* To this end, our clinic is open evenings, staff dress and relate informally, no unnecessary questions are ever asked, and counselors interact with clients in a very cozy, informal waiting room where they provide information and get to know people who may need or want other MIDAC services then or at some future time.

Besides providing free outpatient services to the community, the clinic also provides the initial physical examinations and ongoing medical care for clients in MIDAC's residency program.

Residency Rehabilitation Program

Charles is a 22-year-old, black youth from Des Moines' inner city with the familiar background of a broken home, family on welfare, incompleted high school education, transient and minimal work his-

tory, first illegal drug use in the early teens, a number of criminal offenses related to supporting his habit, and several previous attempts at withdrawal from heroin, including once with the assistance of nothing but chocolate bars and a lot of maternal support. He had even participated for 4 months in an out-of-State drug residency program and had been back in the city for only 3 months and was beginning to slide again when MIDAC opened the doors of its residency program. Charles was among the first group of heroin addicts to enroll in the program. That was in March 1972. He is now on our staff.

Charles knew of us because he grew up with one of our counselors. Unlike many larger cities, Des Moines has a core population which has remained reasonably stationary. The inner city, especially, is like a large traditional neighborhood where a lot of people have lived and known each other for a long time. We use this to our advantage, and one of our staff had been talking to Charles as both friend and MIDAC counselor from the time he returned to town.

Our counselor also knew about heroin from his own former use of it. Like other rehabilitation programs serving hard core drug abusers and heroin addicts we have found that it pays to *recruit former drug users and others with similar cultural backgrounds as the basic paraprofessional counseling staff*. We have found that staff are not only ineffective as counselors, but oftentimes can cause further problems when they try, however sincerely, to work with clients whose backgrounds or personalities are far different from their own. For this reason, too, we carefully *select professionals and consultants with the real life experiences that enable them to identify meaningfully with the problems and personalities of drug abusers.*

The residents and staff of the rehabilitation program are referred to as the family and call each other brothers and sisters. Like its precursor, Synanon, and other "therapeutic community" drug rehabilitation programs around the country, we emphasize mutual concern, honesty, maturity, and responsibility. Daily family meetings, therapy and confrontation growth groups, recreation and social activities, work assignments, and vocational and educational planning and training are integral parts of each individual family member's growth plan.

We are currently exploring the possibility with Goodwill Industries of designing a sheltered workshop for drug abusers which would combine our differing areas of accumulated expertise. Such expertise sharing has already been accomplished with the State vocational rehabilitation department by having carefully selected one of their counselors for full-time placement in our program.

We have to sell our program, not only to the community at large, but to our potential clients as well. Like Charles, most of them have tried changing and failed enough times already to be too eager to do so again. And their skepticism is fully warranted, too. They know that the success story of Charles is not that common, and they wonder how long even Charles can remain a success. But then we remind them (and ourselves) that there is no choice but to try, that drug addiction is simply one of many human disorders which we still understand little about. Cancer cannot always be cured, tuberculosis can only be arrested, diabetes and epilepsy must be continually controlled, and chronic criminal, schizophrenic, or alcoholic behavior patterns are notoriously difficult to change permanently. Disappointments have often been minimized, fears allayed, and criticisms forestalled by our willingness to *inform community and clients alike of the high failure risks which are involved in drug rehabilitation today.*

Our program is designed to accommodate 60 residents at a time, each expected to spend 6 months with us before graduating. Yet nearly half who enroll have dropped out after an average of only 2 weeks. Some who dropped felt they were ready to stay clean, others complained about the program structure and lack of freedom, others missed their families and girl friends too much.

One individual, Johnny, 20, who had been released from jail to enroll in the program, decided after 2 months that the "stress" was too much and chose to return to jail. Johnny, however, was from a white, upper middle class family in a small urban Iowa community where jail for him might not have been particularly stressful.

Sally, 37, was a person who began, dropped out, and reentered the program. She was raised on a farm, came to Des Moines after high school graduation, and since had been hospitalized on many occasions for depressions. She had abused barbiturates and tranquilizers for many years, quite legally, through the unwitting colusion of welfare agencies and physicians who simply responded to her unceasing complaints of insomnia and nervousness. Charles, Johnny, Sally, all came from very dissimilar backgrounds, but were brought together in our residency program in trying to conquer the problems related to a shared history of drug abuse.

A look at the family records would show that the residents were 59 percent male, 63 percent black, 60 percent single, 77 percent had been addicted to heroin with a typical habit costing $80 a day; 57 percent did not graduate from high school, and their median age was 24. Forty percent of the clients were on probation, and the typical individual had a criminal record of three arrests, one conviction, and 7 months in jail. Nearly 40 percent of the family members were female, white, or married, and almost a quarter of the total were strung out on drugs other than heroin (excluding marijuana).

Some programs in larger cities have separate programs for culturally different groups, but MIDAC experience so far has shown this to be unnecessary. Our family members are a varied group, but the drop-out rate still compares favorably with programs having more homogenous clients, so we do not anticipate the need for separate families.

Clients who enter the program typically meet first with counselors in outpatient individual and group sessions. They are then staffed by an intake committee composed of representatives from several community health and supportive service agencies with whom clients are likely to have had previous contacts. They also undergo physical examinations in our clinic. Provided their motivation remains strong and we have found no compelling legal or medical complications which would preclude their participation, clients enter a 2-week orientation to the residency program in small groups of 6 to 10, thus encouraging a family intimacy from the beginning.

The orientation process focuses upon program philosophy, procedures, and expectations, and begins the process of staff and clients getting to know one another more honestly. This occurs at a house in the neighborhood of highest drug abuse, which avoids the initial fears many addicts have of leaving their neighborhoods. Those who complete this phase are initiated ceremoniously into the larger family in our mainstream residence located in the former YWCA building. There they participate in the work-in and workout phases, each expected to last 2 or 3 months, before moving back into the community.

We have a policy that, while we *do not permit a person to be both client and staff member simultaneously,* clients do play leadership roles in the family, and we are eager to have graduates join our paid or volunteer staff. Some of our most disagreeable early learning experiences resulted from the presence of unreformed reformers on our staff. More than any other single factor their employment hurt our credibility and reputation among prospective clients as well as with the general public. On the other hand, we readily take the chances we ask of other employers and give rehabilitated clients priority in our hiring practices. Staff who may relapse into drug use are discharged and encouraged to become clients. This happened to Sally.

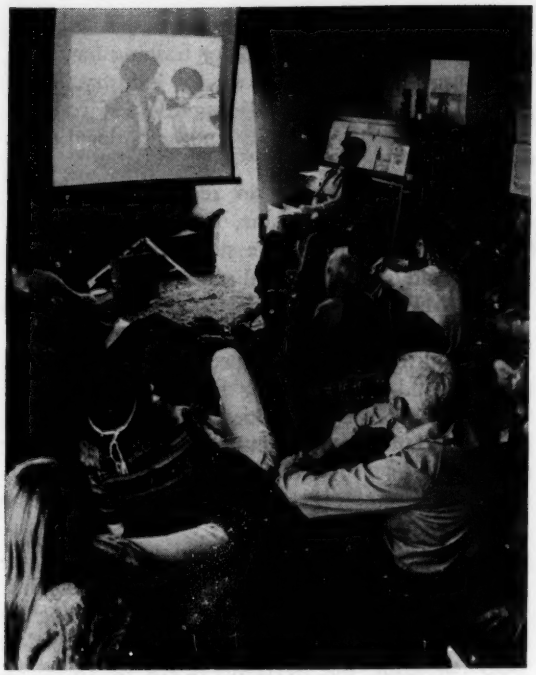
Neighborhood Drop-In Centers

Before entering the residency program, Sally was a client of one of the neighborhood drop-in centers. Like many, she insisted for a long time she could change with minimal support. She did not, at least not for long. Many can, though, and many do. For them we have three neighborhood contact house centers, two in Des Moines and one in Ames, where Iowa State University is located. The latter is sponsored jointly with the Ames YMCA and the Ames Community Council on drugs.

These centers serve a multitude of purposes. They are drop-in counseling and crisis intervention centers where youth can get help in coming down from a bad trip, discuss family hassles, participate in an encounter growth group or a 24-hour "rapathon," or simply be with others. The centers provide opportunities for formal or informal, regular or drop-in, individual or group, and family or couples counseling; whatever may be needed. Professionals provide training and case supervision to the paraprofessional house staffs. Many runaways have been reunited with their families with help at the centers, which also serve persons like Sally who may be on their way into or out of the residency program.

Perhaps the most valuable preventive programing engaged in by MIDAC occurs at the neighborhood centers. Each house has a planning committee composed of volunteers-clients-participants. (We have never been certain of what to call them.) They work with staff to *initiate, plan, promote, and implement alternative activities for youth and the community.* Examples of such alternatives are a weekend coffee house, classes in subjects ranging from geodesic dome construction to yoga, guitar and rock music lessons and concerts, free food concessions at youth gatherings, a monthly newspaper, participation in social and ecological activities, an all-day fast which raised $700 for the Bangladesh Relief Fund, and a free clothing exchange store.

We encourage staff and clients to become involved in a variety of individual, social, political, and



Seminars at one contact house attract many participants. Many approaches are used, including liberal use of audio visual materials. Informality adds to relaxed atmosphere and is conducive to group interaction.

community activities, especially those designed to effect positive social changes. Our emphasis on participating with others in many facets of life simply reflects our *stress that a better alternative is both the best prevention and the best cure to drug abuse.*

In line with this, we have organized student-teacher groups within the schools to work toward starting programs and effecting the changes—"Changes" is the name of this program—that will make the educational processes more responsive and relevant to the needs of the students. The groups decide for themselves what roles they will play in their own schools. Working for such changes, of course, is considered a better alternative than dropping out.

Neighborhood center staff also provides consultation and technical assistance to smaller communities in central Iowa. A police chief of one rural town, for example, came to Des Moines to ask us what he might do in his town of 6,000. "Too many heads spending too much time doing nothing, except smoking pot and shooting the hard stuff," he said. Our own research months earlier had revealed some of the former, none of the latter, and no desire on the part of either the youth or the adults for any drug programing. In fact, they had feared our presence would bring about a problem where they felt none existed. This has happened in other communities, too, but now that drug problems are more prevalent and more visible, we have had increasing requests for assistance in community organization, setting up programs, and training staff in first aid and drug counseling.

Like many law enforcement personnel, the police chief of this rural community hoped we might help him get the pushers. When the need to *maintain the confidentiality of all individuals who are or might ever become involved in drug program services* is carefully explained, however, we have had excellent understanding. We would, of course, quickly lose our credibility among drug abusers and, thus, our *raison d'être* if we did not insist upon the strictest counselor-client confidence. Fortunately, Iowa law also recognizes this and gives drug rehabilitation program clients the right of privileged communication.

While we cannot reveal information about individuals to the police, however, they can and do often bring individuals to our attention. Not just after arrests or convictions, either. Police have frequently brought youth to us rather than arrest them, and they have given us the names of persons to contact whom they have reason to think might have a drug problem. MIDAC staff regularly participates in a half-day training session with each new class of police cadets in order to assure continuance of such cooperation.

Others who often bring the names of possible drug abusers to our attention are worried parents. Usually when this happens, we have a counselor contact the youth to assess the situation and offer assistance. Oftentimes, there is no problem, and we are able to reassure the parents. When there is a problem, we offer help to both parents and child.

One of our programs, exclusively designed for parents, is Parents Anonymous. It is jointly sponsored by the YWCA and MIDAC. There are now three chapters, the original one for parents of present and potential drug abusers, one for parents of runaways, and another for families of youth committed by the courts to a local work-release institution. Each chapter meets at the YWCA twice monthly in groups cofacilitated by MIDAC and YWCA staff.

Drug Line

The neighborhood centers also provide support and serve as referral sources for Drug Line, MIDAC's 24-hour counseling and crisis intervention service. Linda is a regular caller of Drug Line. Ordinarily she is unhappy and just wants to talk, but twice she required medical attention, once for an overdose of barbiturates, once for a bad "acid" trip. Both times, Drug Line notified the neighborhood center closest to her and staff picked her up and took her to the hospital.

Since bad acid trips typically do not require medical attention, our staff quickly located the seller of the alleged "acid" and obtained a sample for analysis. The seller destroyed the remainder of his supply when he was informed that it was not acid, as he himself believed when he purchased a large quantity, but was a harmful rust removal substance. We *make a point of knowing the community well, including those who sell and push drugs on the street.* Through arrangements with a State hygienic laboratory, we can *get street drugs analyzed and inform the community about their contents, potency, purity, and effects.* While some have expressed concern that this service subtly condones drug taking, we counter only that its purpose is simply to minimize the harm which people might do to themselves out of ignorance of what they may take. Linda and the seller have both been more careful since their experience.

Drug Line also refers adults who have problems with legal prescription drugs to Narcotics Anonymous. Narcotics Anonymous is a national, independent organization modeled after Alcoholics Anonymous. We helped begin the local chapter and now simply provide a telephone referral service for present and prospective members.

Drug Line telephones are manned by more than 90 volunteer counselors who participate in a training program which involves 21 hours of orientation, 2 to 6 months of counseling apprenticeship training, ongoing case supervision, and biweekly training sessions with paid professional mental health staff. Drug Line is a cooperative venture of MIDAC, Youth Line, Des Moines Child Guidance Center, the YMCA, and St. Paul's Episcopal Church, each of which contributes funding, facilities, or professional personnel.

Finally, staff of all MIDAC programs cooperate in providing educational programs for the central Iowa area, ranging from one-time speaking engagements, to ongoing counselor training for other agency personnel, to symposia for industry, labor, medical, academic or other supportive service institutions. And staff frequently appear on local radio and television shows.

Thousands of contacts are recorded monthly in the activities of Drug Line, Parents Anonymous, Narcotics Anonymous, the neighborhood drop-in centers, and our educational activities.

And MIDAC is still growing. Plans exist for a methadone maintenance outpatient program, an expanded drug information program in the public schools, and for beginning neighborhood contact centers in more communities outside Greater Des Moines. Our purpose is simply to *provide whatever alternatives in drug education, prevention, and rehabilitation might help alleviate the problems of present and potential drug users.*

Presently we have a paid staff of nearly 50 persons whose efforts are devoted full time to doing this. They are assisted by countless volunteers. Among the most active volunteers are the 25 community leaders who constitute the MIDAC Board of Directors, specifically selected to achieve organizational, geographical, and consumer representation. They play an indispensible role in securing the community and financial support necessary to implement the policy and programing which they establish.

MIDAC presently is funded federally by the Department of Justice; the Department of Health, Education, and Welfare; and the Office of Economic Opportunity. Local funding is provided by the city of Des Moines, Greater Des Moines United Way, and contributions from numerous smaller municipalities, school districts, businesses, and other agencies and individuals.

Are we successful? By the criteria of numbers of clients served, yes! By increasing appreciation on the part of clients and general public of the kinds and quality of our services, yes! By our ability to attract Federal and local funding, yes! By increasing offers of volunteer assistance from very different individuals and groups, yes! But how many addicts will remain clean for how long, how many do we keep from ever becoming addicts, and how many parents, teachers, employers, or police have been kinder to youth because of our efforts? Unfortunately, it is difficult to find ways of answering these questions. Until we can, we point to Peter, Charles, Johnny, Sally, Linda, and others like them who may be alive today because of MIDAC. ■

Making It Work

Elliot L. Richardson

Secretary of Health, Education, and Welfare

Something has gone terribly wrong with the way we try to help our fellow Americans. It isn't that we don't care. And it isn't that we don't try. One of the very best things about this country is that we have never lost that willingness to lend a hand when a neighbor is down or hurt and honestly can't help himself.

But more than time separates us from the day when helping out meant rebuilding a man's barn. It's gotten a lot more complicated. The person needing help today might be an isolated old person, without friends or family; or a child in an inner-city slum. His needs are likely to be many and interrelated—things like the wrong kind of food or not being able to read or write, or a crippling disability, or alcohol or drugs—all compounded by a sense of complete hopelessness. And these problems can get tangled together in one person like a ball of fishhooks.

It's a situation which crept up on us over the years.

As things got more complicated we kept trying to take them apart and make them simple. What happened was that as people's problems became more complex, we began producing specialists in problems but very few specialists in people.

Take HEW, for example: eight of every 10 of the men, women, or children who need help from us need more than one *kind* of help. But we go at the job "program by program." We take people apart and try to make them fit into all the various titles and acts of Federal law. This approach has never worked well and today, when awareness of human problems is so acute and when so many potential solutions are at hand it has become tragically inadequate.

HEW is responsible for more than 270 specialized programs of human assistance administered by dozens of State and local agencies. Human beings get lost in the process, if they can get in it at all.

Today people are demanding a change. Proponents of change include the people in my Department, social service workers, health and education specialists, government leaders, and people in need. They all agree we have to go back to viewing people as whole individuals and treating them in a way which eliminates waste and duplication and still gets the job done.

The problem does not lie entirely or even principally with the professionals who are trying to help. The doctors, the teachers, the social workers who work within the system are frustrated by it, and the better and more caring they are, the more frustrated they are. The problem is the system—the laws, the rules, the regulations, the traditions which have grown up over the years until they have become an impenetrable thicket. It's the system we must change.

I would commend one proposed solution for your consideration. It is a beginning. HEW has sponsored, and the President has introduced, a new law called the Allied Services Act. It would take this approach:

It would help States and local communities pay the costs of developing total and systematic approaches to the delivery of human services.

It would give Governors the authority and the tools to lead the way in building strong statewide service systems.

It would encourage State and local agencies to develop new approaches for linking up diagnosis, referral, treatment, and followup. And it would pull together the front office management of social services to make it more effective and less wasteful.

Specifically aimed at HEW's vast array of "programs," it would allow States which have done the necessary planning to shift up to 25 percent of HEW funds out of the old narrow specialized channels to match them up with local resources and local needs.

We have learned a lot about how to help our fellow citizens. We have created useful agencies, institutions and programs to work on problems. But to really help people get back to independence we have to get these specialized agencies and programs to work together to treat the whole person.

The Allied Services Act is one proposed solution. It is not the only one or the final one. But as the Congress, the Federal Government, and your State and local governments approach this complicated and important problem in the next few weeks and months, I would hope that all of you as concerned citizens will study the issues involved and insist that we begin the job of repair and reconstruction. It is too important to be left to specialists.

The Allied Services Act would (1) enable a coordination of complementary but currently separate services at State and local levels and (2) provide the necessary tools to allow State and local government to eliminate bureaucratic obstacles. This is necessary in order to promptly treat social needs and speedily remove social dependency.

What The Act Will Do

For The People Served:

- Provide for comprehensive problem diagnosis and service planning.
- Enable a range of services to be accessible through integration of separate service institutions.
- Transfer the burden of responsibility for getting appropriate services assistance from the people to the system.
- Improve convenience through consolidation and simplification of forms and procedures.

For Governmental Effectiveness:

- Bring State and local elected officials more directly into the delivery of services business.
- Encourage the creation of State and local integrated service plans through a project planning grant authority.
- Authorize the Secretary of HEW to waive categorical, regulatory, and technical provisions which impede the integration of services.
- Insist as a prerequisite for State planning aid that common service areas be established.
- Authorize the Secretary to consolidate the planning of all HEW administered programs, included in State and local Allied Services programs, into a single planning grant.
- Permit the transfer of funds among specified HEW programs to achieve maximum effectiveness.

How The Bill Will Work

As a first step, the Governor of a State must choose to participate and designate common service boundaries.

Local plans would be developed by local elected officials, or combinations thereof, which would involve the various public and private providers of human services.

Local plans would be consolidated by the Governor into a State plan for approval by the Secretary of HEW.

A minimum of four human services programs, including the public social services program, must participate in State and local Allied Services plans.

What The Bill Provides In Assistance

The Act:

- Makes available federal assistance in the form of planning and implementation grants, fund transfer, and waiver authority, for State and local officials.
- Provides incentives for the planning and implementation of goals rather than impose mandatory nationwide standard requirements.
- Authorizes State and local elected officials once plans are approved, to transfer up to 25 percent of HEW funds between programs included in the plan depending on their priorities.
- Permits the Secretary of HEW to waive statutory or regulation-based restraints and provide grants to cover start-up administrative costs of putting these systems in operation.
- Empowers the Secretary and the States to consolidate the planning authorities across the programs participating in State and local Allied Services plans.

What Will This Cost

It is estimated that up to $20 million would be required for planning and implementation grants in the first full year.

Federal programs subject to being coordinated under the Allied Services Act involve several billion dollars. ■

What It Means To Be A Volunteer

Diane S. Roupe

Inherent in a discussion of "What It Means To Be A Volunteer" is the necessity for expressing a very personal viewpoint and judgment.

There is considerable lack of understanding and consensus about the meaning of volunteerism. While the concept is ancient, volunteerism has not been very fully developed by man, nor has it been widely recognized as a viable solution to the problems which have plagued mankind through the ages. Volunteerism deals with human relationships—the area in which civilization has perhaps made the least progress. Through the evolution of civilization, man has placed emphasis on material growth, the arts, governmental structure, and education, and our level of attainment in these areas has been exceedingly high. However, man has not directed enough attention to the refinement of human relationships, and the world is paying the price for his neglect.

Mankind is waking up to the realization that human existence is dependent upon more than materialism, the arts, government, and education. Man is beginning to realize that none of these societal endeavors can supplant the need for mutual helpfulness among human beings. We are in the middle of one of the most turbulent eras in history. There is cause to wonder if the human species will be able to keep from annihilating itself. Perhaps the answer to that question rests upon whether or not man is learning the lesson of human interdependence—the principle that survival of the individual is dependent upon his unselfish interaction with other individuals and with all creation.

The world's greatest teachers, philosophers, and religious prophets have instructed mankind about the imperative of mutual helpfulness since the beginning of recorded time. Confucius stated the golden rule in 500 B.C. Surely the principle of man helping his fellow man is as old as civilization itself. In fact, I believe that knowledge of the necessity of man helping man is inherent to every human soul. An individual does not have to rely on the words of the great teachers of the ages regarding the veracity and workability of mutual helpfulness and mutual dependence. For evidence, man has only to look into his own being and investigate his own experience.

I believe that one of the primary reasons for the sudden surge of interest in volunteerism is growing awareness that the volunteer concept is a prime vehicle for implementation of the principle of people helping people. Volunteerism is a latent tool waiting at man's fingertips. Volunteerism is a very simple tool. It is a very basic tool. Like other simple and basic tools, such as the wheel and the hammer, it can be applied to the solution of very complex problems. Volunteerism can go a long way toward helping mankind solve its most difficult tribulations—toward helping mankind heal the wounds of human affliction which are so widespread across the face of the earth.

Being a volunteer means giving to another human being—giving your friendship and your understanding. Being a volunteer means sharing yourself with other human beings—your talents, your time, your energy, your mind, your experience, and your expertise.

I believe that volunteerism is a key missing link in our rehabilitation delivery system—in vocational rehabilitation and in the whole field of public assistance. The delivery of service to clients by paid professional staff, within the confines of a facility, cannot, by itself, accomplish the complete and satisfactory rehabilitation of an individual. People caught in the dismal treadmill of public welfare cannot become disentrenched through monthly checks, food stamps, and even job training, alone. *Citizens*—individually and collectively, as the community—are required to complete these processes. Vocational rehabilitation and public welfare are addressed to the habilitation or rehabilitation of in-

Mrs. Roupe is chairman, Volunteers in Rehabilitation Project, Goodwill Industries of America, Inc.

dividuals to the world of people—to society. Volunteers *are* society. They are one of the best links between the clients and the world into which we are trying to help them integrate and successfully adjust. Rehabilitation service in our country is too much a matter of incubation for clients and not enough a matter of exposure and acclimation to the world.

Consider the benefits of a volunteer and client, who share a common interest in art, taking painting lessons together at the art center. The client gains a new, meaningful mode of self expression. He finds a useful way to employ his leisure time. He meets other people in the community who share a common interest. He may become involved in other activities at the art center and thus broaden his scope of involvement and circle of acquaintances. The volunteer may invite the client to his home for dinner or for other social occasions. The client gains greater understanding about social interaction and learns social graces. Most of all, the client gains a friend—a person whom he knows cares about him and what happens to him; a person who wants to help; a person who respects him as an individual of worth; a person he trusts and in whom he may choose to confide. The client develops confidence in himself as he experiences interaction with people in the community. He begins to better evaluate and envision how he can secure a meaningful place for *himself* in society.

All of the benefits in the example I have given do not supplant the need for professional training and service back at the facility. I am suggesting that in order to complete the rehabilitation process . . . in order to really "close" a case . . . greater emphasis must be placed on getting the client out into the real world. And volunteers have the capability of accomplishing this with clients.

In order for the client to be assimilated into society, society must be willing to assimilate him. Here, again, the volunteer can be the facilitator. The volunteers, themselves, become aware of the needs of clients in society, and they help convey these needs to other people in the community. Volunteers are one of the best means of educating people in the community about the problems and also the capabilities and special contributions which handicapped and disadvantaged persons can make. If the community understands, the community will be more likely to act to correct inequities. At the art center, the client begins to be recognized as an individual who is gifted in painting, or a person who possesses a deep and special understanding of life, rather than as a person in a wheelchair who has limitations, or a person who is very different because he is deaf. Job placement opportunities will also open up when more volunteers become involved in the rehabilitation process. Greater community understanding of handicapped people will breed more positive attitudes which, in turn, will open up a myriad of new opportunities for clients.

A volunteer extends his life to other life. And when life extends to other life, a mysterious and miraculous thing happens: both lives are enhanced. Mental, emotional, and spiritual growth occur in both lives.

Being a volunteer means receiving from others. Volunteers often express bewilderment when they first begin to sense that they are perhaps receiving more than they are giving. Volunteers discover that every human being has something worthwhile to give and share with every other human being. Perhaps one of the most profound lessons which volunteers learn is humility. It *is* true that some of the seemingly least among us are some of the greatest among us.

Through volunteer work at the Mid-Iowa Drug Abuse Council, I have made friends with heroin addicts, hippies, and prostitutes. I

What It Means To Be A Volunteer

Giving . . .
from the center of one's being.
Receiving . . .
from lives blessed with courage and rich understanding.
Helping . . .
to bring mankind closer to Truth
as one perceives it.
Feeling Oneness . . .
with ourselves and with humanity.
Tasting Eternity . . .
through investment in other life.
Finding Faith . . .
in the human soul and the ultimate order of all things.
Being a Friend;
Having a Friend.
Touching . . .
other lives.
Being Touched . . .
by other lives.
Caring.
Sharing.

treasure many of these friendships. These friends have imparted much to me, and I hope I have helped them, they gain wisdom and insight When people experience agony and despair, and attempt to rise above them, they gain wisdom and insight into life which most people never achieve. Courage and strength become the products of their pain. From them, I have learned courage and have gained strength. Every single one of them is basically good. Their basic goodness and their responsiveness to someone who cares, constantly inspires me to extend myself more to them and to others caught up in the same dreadful web.

At the drug center, no one is concerned about where you live, whether or not you hold a college degree, or what label is on your clothes. There, they are concerned with what you are and what you think—not with what society says you are, or with what you may pretend to be. Last names are not important. Everyone is known as a brother or a sister. I can tell you that no honor or title I could ever earn will mean more to me than the one I have at the drug center—Sister Diane.

In turn, I think I have been able to restore some of their lost faith in organized society, or "the establishment" as they call it. Through association with volunteers, my friends at the center have learned that there are people with short hair and conventional clothes who also think much as they do.

Last Christmas, a group of these friends came to our house for a full day of cookie baking. To give you an idea of the number of cookies we baked, we used 25 pounds of flour. The cookies were delicious, but they were not the most important product of the day. The most important thing that happened that day was the achievement of greater appreciation for one another and our particular styles of living. Through them, I learned that what a guest in our home may wear, does not matter—that does not make him more interesting company. It is what he thinks that matters. By being in our home and meeting some of my other friends, my drug center friends learned that not all the people who live south of Grand are materialistic, selfish hypocrites.

In the rehabilitation of drug abusers and people alienated from society, what could be more important than this kind of experience with people in the community? And what could be more important for people in the community than finding new understanding and appreciation of fellow citizens who need to find dignity and self-fulfillment in conventional society?

Being a volunteer means caring. Volunteers take with them, wherever they serve, a special quality of caring which cannot be duplicated. Client after client, whose lives have been touched by volunteers, will tell you that just the fact someone helped them who was not being paid in dollars and cents, had a tremendous impact on them. Credibility in the world of people is restored through volunteers who care. Clients who have experienced this phenomenon say: "He or she must have *really* cared about me; otherwise, he would not have come to help me week after week."

Being a volunteer means an opportunity to use one's special knowledge, skills, and talents. To be a volunteer is to be in one of the most ideal roles in our society. The role affords optimum opportunities for fulfillment, self-realization, growth, and mental health.

Not only do the volunteers benefit from the use of their special skills, the entire rehabilitation program benefits. Volunteers can expand and augment the professional services which facilities are able to provide with paid staff. We have neither the financial resources nor the trained personnel available to deliver the full complement of rehabilitation services in this country. Volunteers can help fill the gaps. Properly recruited, trained, and supervised volunteers can contribute greatly to the service delivery team. Volunteers must never supplant paid staff; volunteers must augment paid staff.

A volunteer's special abilities should be utilized in his volunteer job. A trained physical therapist who volunteers his or her time should not be put to work stuffing envelopes, unless he particularly re-

Innovative Volunteering

One of the most innovative forms of volunteering now becoming popular is done by whole families together, to take along a few extra persons who would not otherwise have a chance to visit a zoo or a beach on a 1-day excursion. Others open their homes for weekend or holiday visits for persons unable to be with their own family. Growing out of the wonderful experiences which handicapped clients have had while visiting families who volunteer their homes has come the concept of volunteer "respite" homes, too, which take an occasional guest for weekend or vacation period so that his own family can have a respite for carefree recreation and enjoyment. Such respite shows up the family strengths so that members can continue to carry the responsibility for a member who needs extra consideration and care, preventing long term custody in institutions or foster care.

—Harriet H. Naylor
Director Northeast Region, National Center for Voluntary Action

quests this type volunteer job. Volunteerism is sometimes erroneously equated with nonprofessionalism. Volunteers are people. Volunteers have the entire range of abilities and experiences which the population has.

Research conducted as a part of the Volunteers in Rehabilitation Project,[1] revealed the demographic characteristics of volunteers presently serving in rehabilitation facilities. Ninety percent of the volunteers in rehabilitation facilities in this country are female; 60 percent are 35 years of age or older (only 40 percent of the total population falls in this age category); about 40 percent have had some college or hold a college degree (only 20 percent of the total population has this educational background); only 1 percent is handicapped; and only 1 percent is socially and/or culturally disadvantaged. So, demographically speaking, what it presently means to be a volunteer in a rehabilitation facility, is that you are probably female, you are probably over 30, you have had more formal education than the average person, and you are neither handicapaped nor disadvantaged. Volunteerism needs to spread over the entire population. Volunteer service can add meaning to the lives of all people, no matter who they are, where they are, or what they are doing: youth, retired people, blue collar workers, people in business and the professions, people from the inner city, people from all ethnic and minority groups, people with all kinds of handicaps. All have their special contributions to make through voluntary effort. All have the opportunity to grow and find a useful niche in our complex society through volunteer service to others.

Especially in the field of rehabilitation, we need to consider the habilitative aspects of volunteer service which accrue to the volunteer. Volunteer activity can be an important adjunct to the rehabilitation of handicapped and disadvantaged persons. It provides a chance to give to society, rather than just receive. Volunteer service can be a circuit to self-identity and self-esteem. Confidence, experience, and work skills can be personal benefits that individuals can receive through volunteer activity.

A volunteer is in a position of great freedom. One is free to select the area of activity which calls him the most; one is free to apply whatever personal ingenuity, energy, and creative planning he can generate, to projects he believes will improve society. A volunteer is free to organize his or her own time. A volunteer can move freely in society to get things done. A volunteer can communicate with, and attempt to motivate, the political structure, organized groups, and single individuals to accomplish the goals which he or she has selected. While professionals in government or private agencies may have substantial opportunities for accomplishing many of the same things which volunteers do, employees must operate within the confines of an organizational structure. Even where there is maximum latitude and encouragement for cooperation with other agencies and social structures, there is not the complete freedom which is available to the independent volunteer. Of course, volunteers who function within organizations do not have total freedom in matters directly relating to those organizations and their clients.

As a volunteer, one can exercise extraordinary influence to get things done. People or agencies from whom a volunteer seeks cooperation or money know that he is not motivated by self-interest—he has no personal ax to grind. In a day when public officials are deluged with lobby activities of self-interest groups, they seem to be refreshed by, and pay considerable attention to sincere volunteers whose goals are selfless. A volunteer has the political ear. A volunteer also has the ear of most businessmen. Businessmen, who tend to be profit oriented, are especially sensitive and sympathetic to requests from volunteers. They express over and over again their appreciation of the fact that there are those in the community who are willing to offer time to concern themselves with social problems. They admire and respect a volunteer's willingness to work without monetary reward.

Being a volunteer means finding faith in the human soul and the ultimate order of all things. Volunteerism endorses the truth that every life is sacred and worthwhile. Through activities with clients from highly varied backgrounds and with a wide range of abilities and disabilities, volunteers verify the fact that pride and desire for dignity cannot be extinguished in the human soul . . . that human beings all possess the same basic desires . . . that every life can be worth living . . . that no human situation is hopeless.

Through volunteerism, one begins to feel and experience the mystical interrelationship of all people and all things. One begins to get some small inkling of the oneness of the universe.

Intrinsic to human life is the rule that the only things we really keep are those which we give away. A volunteer experiences the indisputable proof of this spiritual law.

A volunteer learns to share what he has, and a volunteer learns to accept the gift of friendship and understanding from others. In the rehabilitation process, this is the greatest value of volunteers—the sharing of friendship between a client and a person from society who cares. Upon such friendships, faith in oneself and faith in other people can be restored. Upon such friendships, lives can be rebuilt.

Note

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Volunteers In A State Agency

Edward J. Aud

The administrators of the Oklahoma Rehabilitation Service decided to explore the practicability of utilizing well-trained, rehabilitation-oriented volunteers in 1961[1] when it became apparent that an existing time-lag between onset of disability and referral for services was expensive in terms of increased costs of rehabilitation, depression of client morale, and loss of confidence and motivation. These undesirable factors also resulted in increased dependency on the client's part.

Examination of these conditions revealed that we were doing an inadequate job of maintaining contact with and providing supervision for clients from rural areas who were hospitalized in urban medical centers. Rehabilitation counselors "officed" in metropolitan areas carried large caseloads and were unable to visit these clients. Problems of distance and insufficient funds often made it impossible for relatives and friends to visit them.

Rehabilitation volunteers, we reasoned, could make hospital visits and enable the agency to maintain contact with lonely and apprehensive clients in strange surroundings far from home. Also they would serve as continual reminders to the hospital personnel of the availability of services, assist physicians in making referrals, and dramatize the desirability of early referrals.

The project was designed to achieve more thorough rehabilitation in the larger hospitals in the two most populous areas of the State through the use of volunteers as a supplemental resource to the State agency. Specific purposes were to demonstrate the extent to which volunteer workers might increase the numbers of referrals from hospital and medical personnel, to improve rehabilitation services through the development of earlier referrals, to insure contact with and supervision of persons undergoing physical restoration, and to enhance agency relationships with physicians, hospital personnel, and the general public.

Project implementation took place in five large hospitals in Oklahoma City and three in Tulsa. Four hospitals had auxiliaries composed of full-time salaried directors and volunteer workers who specified the type and hours of work they preferred. One Oklahoma City hospital did not have an auxiliary; however, Gray Ladies from the Red Cross Chapter performed volunteer work there. Contracts were made with the auxiliary directors and the leader of the Gray Ladies, and their cooperation was solicited.

Each hospital already had volunteers who visited patients and performed other duties for them. Some hospital administrators and directors of the auxiliaries felt that it might decrease their operational effectiveness if other volunteers were assigned to serve a specific group of patients for an agency not within the administrative jurisdiction of their hospitals. The auxiliary workers were interested in service to patients, however, and visiting the agency's clients would not impose a heavy additional burden upon them.

The project personnel consisted of a technical director and a coordinator of auxiliary services. The technical director, a registered nurse, worked at the Oklahoma City hospitals; the coordinator, a social worker, worked in Tulsa. They were selected be-

Mr. Aud is Director, Oklahoma Rehabilitation Service.

cause of their familiarity with hospital procedures, their experience in working with medical and paramedical groups, and their understanding of the services and procedures of our agency. They were personally acquainted with most of the hospital personnel. This enabled them to arrange for auxiliary members to become visitors with complete understanding and cooperation from everyone concerned. Some auxiliary directors accepted the proposal almost immediately, while others referred the request to the Auxiliary Board for approval. They made many suggestions that helped mesh the project operation with the hospital routine.

The Oklahoma and Tulsa County medical societies were appraised of project objectives, and their advocacy was invaluable. Also, individual physicians and paramedical people were acquainted with project aims and goals. Each hospital administrator designated one person—a head nurse, social worker, or physical therapist—to remind busy physicians that vocational rehabilitation might be suitable for certain of their patients.

The technical director and coordinator depended upon the judgment of the auxiliary director in making the final selection of visitors in each instance. Selections were made on the basis of interest in community service, tolerance and understanding of people, patience as a listener, flexibility, responsiveness to others, warmth, and thoughtfulness and sensitivity toward and interest in the welfare of other persons.

Rehabilitation program orientation was provided the first group of volunteers. Attendees included auxiliary workers, registered nurses, some directors of nursing, social workers, and ministers. Directors of nursing, ministers, and social workers attended to learn how to use the agency as a community resource. Orientation consisted of the historical background, philosophy, objectives, and legal responsibilities of the agency; the counselor and his responsibilities; the physical restoration program; and the purpose of volunteer visits. This agenda also outlined to each visitor precisely what her responsibilities were to her auxiliary, to the clients, and to the agency. Visitors were advised that their visits were not to be used as rehabilitation counseling sessions, but were primarily for morale building, public relations, facilitating early referral, and keeping the counselors informed of their clients' progress.

Later, as the project was extended into other hospitals, similar orientation programs were conducted, although they were condensed into shorter time periods. Many followup discussions were held. This resulted in an informal but continuing inservice training program. This was essential as there were many changes of personnel in the auxiliaries. New volunteers, in some cases, came into the program as often as once a week or even more often.

Visits were made to both clients and potential clients. Sessions with potential clients were most demanding, since they required more explanation of the reasons for the visit and a general discussion of the services provided by the agency. These visits required more support from the technical director and coordinator. Potential clients were individuals referred by physicians and paramedical personnel. Questions were answered regarding services and an informational brochure was given to them. The visitor completed a referral form during the visit. In addition to basic referral information, this form provided finding directions to the client's home, the name of his family physician, and whether or not the referring physician had told him about vocational rehabilitation. The visitor explained that the information would be sent to the rehabilitation office nearest the client's home and that a counselor would contact him upon discharge from the hospital.

The volunteer who visited clients hospitalized for diagnostic procedures or for physical restoration purposes introduced herself as a representative of the agency. These visits were primarily for moral support and to maintain contact between the client and the agency while he was hospitalized. Clients who spent only 2 or 3 days in the hospital usually received one visit. Those who were hospitalized for longer periods of time were usually visited daily during the first week when apprehension and depression were likely to be most intense. The visitor made certain that the client knew how to contact his local rehabilitation office in the event problems developed. She mentioned that the counselor had asked her to visit and see how the client was getting along.

The social information, provided by the counselor on the "Request for Visit" form was helpful to the visitor in intiating conversation. The visitor assured the client that arrangements had been made for his transportation home following discharge.

Visits to clients were normally made by more than one volunteer, as they usually worked only 4 to 8 hours per week. Continuity of visits and conversation were maintained by asking the first visitor to make notes of her visit. In those instances when

First step in volunteering is knowing the program and what it can do for people. Here, a new group of volunteers in Tulsa, Oklahoma's DVR program take part in orientation session.

daily visits were made the volunteers submitted a visit summary twice a week. It became apparent, as would be expected, that clients were more apprehensive on the day of admission, especially if surgery was scheduled for the following morning. The volunteers, therefore, suggested that the "Request for Visit" forms be submitted in sufficient time for visits to be made on the evening of admission.

Three forms were devised for reporting: "Request for Visit," "Referral to Vocational Rehabilitation Service," and "Report of Visit."

The technical director developed posters, in black and turquoise on white, featuring rehabilitation of individuals disabled by automobile accidents, farm accidents, industrial accidents, and mental and emotional illness. The words "Counseling-Training-Therapy" appeared on each poster, indicating that these services were available to individuals who became disabled. These framed posters were placed in physicians' lounges, on bulletin boards near elevators and near nursing stations, as well as in public buildings and in vending stands operated by blind clients. One State Legislator displayed them in the showroom of his automobile agency.

The volunteer project promoted improved relationships between the agency and the hospital staffs; it provided an increased sense of responsibility and prestige to the hospital auxiliaries; it raised the morale of hospitalized clients; and it increased early referrals without additional demands on the rehabilitation staff. The involved physicians and paramedical people became very cooperative as they learned about the services available. Hospital personnel reported that the morale of hospitalized clients was improved by the visits. Many volunteers stated that their experience in the program enabled them to establish a more comprehensive visiting service for all their hospital patients. Numerous clients wrote letters expressing appreciation for the visits.

There were 557 clients visited during the first 27 months the project was in operation. A total of 688 visits were made to these patients. Most received only one visit because of limited hospitalization. After 1 year, a questionnaire was sent to 100 clients, chosen at random, regarding the program's value. Sixty-one percent responded. The majority were positive. Another questionnaire went to counselors whose clients had been visited. Their responses indicated that the program served a useful purpose and was worthwhile. Many physicians telephoned counselor offices and made referrals as a result of daily contact with project volunteers.

Toward the end of the second year, it was determined that the project could be operated by a smaller staff. During the ensuing 6 months, the project was operated by the technical director and a secretary. Another hospital, in Muskogee, was included. A counselor in the Tulsa rehabilitation office coordinated the operation there. The project concept has been expanded to other areas of the State.

The project was relatively inexpensive. The major cost was the staff salaries. Office space, office equipment, and supplies were not costly. Two consultants, a medical social worker and a rehabilitation administrator, were utilized. Travel reimbursement was provided the project director and paid staff. Taxicab fare was set up in the project for a total of approximately 42 volunteer visitors during the period of the project but was never used, since auxiliary workers were utilized as volunteers. The only other funds expended were for Social Security,

taxes, printing and communications, and office rental. The total cost of the project was less than $45,000, including both State and federal funds. The paid staff was covered by the agency group insurance policy. There was no insurance involvement with the volunteer workers. The agency was not under the State Merit System during the project period.

Numerous problems, of course, were encountered in implementing the project. To the best of our knowledge, the project was the first of its kind in a vocational rehabilitation agency. No guidelines were available. The first obligation of auxiliary workers must, of necessity, be to their hospitals and auxiliary directors. This fact constantly had to be borne in mind. The paid staff did not have direct authority to supervise and control the volunteer visitors. All supervision had to be done through the auxiliary directors. Communication problems developed, as a result, together with some administrative problems, but these difficulties were reduced or eliminated by written procedures which were developed.

Absenteeism, as a result of personal responsibilities, was frequently a problem. The performance of previously established hospital duties held priority, which, early in the project, resulted in a limited number of rehabilitation clients not being visited. This problem was overcome by arranging for "Request for Visit" forms to be submitted at least 2 or 3 days prior to admission. The auxiliary directors arranged to have more than one visitor on duty whenever possible. Several of the directors rearranged schedules to insure that a visitor would be available during late afternoon periods to contact newly admitted clients.

In the beginning, several auxiliary organization members were undecided whether or not to accept this additional responsibility. This caused some delay in initiating the project in certain hospitals. Many conferences with the volunteers were required to sustain interest and improve performance. It was necessary to encourage them, bolster their self-confidence, and sustain their belief that their efforts were of much value. A few visitors were uncomfortable in their roles and requested relief from their assignments.

Training volunteers to write adequate visit reports required much effort. First reports were exceedingly brief. Project staff support and experience in the program, in most instances, enabled the visitors to better evaluate the information provided by the clients. More complete reports resulted.

Because of busy schedules, discussion of project objectives with physicians was difficult. To some extent this was solved by casual meetings with them in the corridors during their hospital rounds. These contacts were helpful in reminding them to refer patients who appeared to be eligible for and able to benefit by rehabilitation services and in maintaining their interest in cooperating with the volunteers.

Another problem was encountered in maintaining the cooperation of the rehabilitation counselors. It was essential to reinforce their understanding of project objectives, by insuring the submission of "Request for Visit" forms and by including social information in order to enable the visitors to establish a "meeting ground" with the hospitalized clients. It was difficult for some counselors, in the beginning, to appreciate the morale aspects of the visits. Some counselors seemed to expect too much from the visits and felt, therefore, that they received too little from them. Inservice training sessions with the paid staff clarified these early misunderstandings.

During the summer months, many volunteers scheduled vacations or remained at home to care for children who were out of school. For a period of time, this resulted in some clients not being visited, but the use of high school girls during these months alleviated the situation.

A State vocational rehabilitation agency interested in establishing a volunteer program should determine, through careful investigation, its best potential sources of workers. Formal and informal continuing orientation of the volunteers is essential. Regular agency staff must be thoroughly oriented concerning the objectives of the program and well grounded in the procedures required to make it workable. Due to frequent changes in volunteer personnel, a concise, clearly written handbook delineating objectives and procedures is of much value. The use of informational and educational material should not be overlooked. Young people may perform a useful role in many volunteer programs. A capable director or coordinator of volunteers is of inestimable worth. Some means of public recognition of the services of the volunteers should be provided by the rehabilitation agency to commemorate their gratuitous contributions to others.

Note

(1) This report is based on a demonstration project in the use of volunteers by the Oklahoma Rehabilitation Agency, July 1961–December 1963, RD Grant 770, supported in part by the Rehabilitation Services Administration, DHEW.

Volunteers in a State Agency For the Blind

Joseph Kohn

Mr. Kohn is Executive Director, New Jersey Commission for the Blind and Visually Impaired.

The State Commission for the Blind in New Jersey came into existence as a legal entity in 1910. Volunteers, one might say, started the agency since, for a year earlier, a group of public spirited women had begun to serve blind people in their homes, particularly by teaching them handcrafts.

The act establishing the commission had a unique statutory statement which is still in existence and says that the commission can do "whatever is necessary to ameliorate the condition of the blind." This gives the agency a very broad base of activity and underpins its philosophy of comprehensive services to blind people. In addition to being an official vocational rehabilitation agency, the commission provides prevention of blindness services, home teaching and social services for the elderly and homebound; it operates a contract workshop program; a rehabilitation center; an extensive home industry program. It is the agency responsible for the education and school placement of blind and visually impaired children in the State.

One might say that the volunteer program developed initially in the agency almost by itself. During the past 20 years, however, individual departments have begun to structure and develop the program because of emerging needs. In answer to one of these perceived needs, in 1971 the commission added a supervisor of volunteers in its table of organization.

Volunteer Roles and Functions

Volunteers are used in a large variety of roles and their activities are administered by the individual departments with which they are associated. The supervisor of volunteers acts as a coordinator for all service departments. In general, her job is to recruit and correspond on new requests; to arrange or provide inservice training; to maintain statistical records on each volunteer, including evaluation of performance; to provide at least annually a combined educational and awards program. We consider the awards program of special importance not only as a reward for service but as a vehicle of public infor-

mation about blind people and as a means of improving public attitudes toward blind people.

The commission uses a minimum of 2,000 to 2,200 volunteers annually, not including the special efforts of Lions Club members who organizationally are committed to the needs of blind people but whose activities overlap the usual volunteer function and include fund raising for support of projects and even direct service roles.

Volunteer functions include the following major areas:

Preschool Vision Screening. As part of its prevention of blindness function, the Commission conducts vision screening programs for vulnerable population groups. Among preschool children we are particularly interested in identifying amblyopia (dimness of vision without detectable organic lesion of the eye) and other early childhood eye conditions since treatment is effective usually only up to the age of 7. Staff nurses arrange for community-wide screenings by agreement with local school districts.

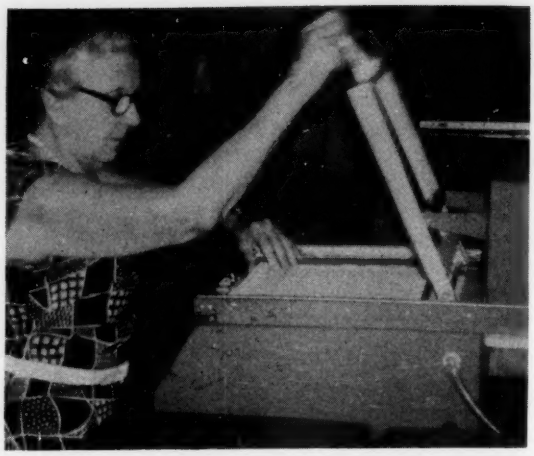
The cooperation of local PTA's, Delta Gammas, and similar groups are enlisted since we wish to use "mother-types" with these young children. Agency nurses then give formalized training to the involved volunteers who become part of an assembly line arrangement for gross testing of vision.

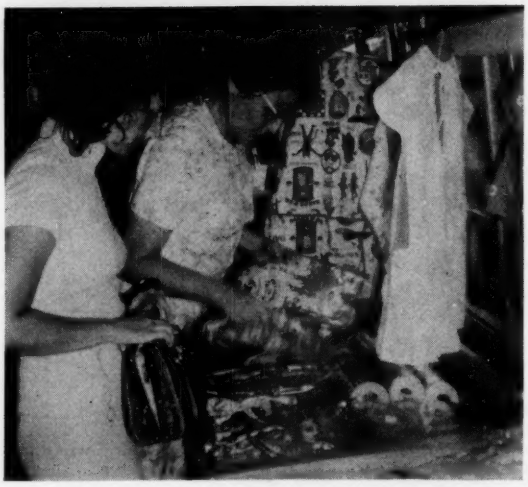
Children who fail the simple test are referred for a professional eye examination by Commission staff who also provide followup into treatment and surgery if required.

About 1,300 to 1,400 volunteers are used annually in this program and there is greater community demand for the service than we can readily meet. A training manual has been developed and is in use. Just over 17,000 children were screened in 1971.

Library and Textbook Center. The Commission education program emphasizes public school placement of blind children. Nearly 1,000 blind children were attending regular community classes in 1971. In addition, several hundred were placed in nursery schools, treatment centers, and/or residential schools for the blind because they suffered from multiple handicaps.

To make this possible, the Commission has a substantial staff of itinerant teachers who visit children in their homes and their community schools, assisting parents and classroom teachers with the child's needs and furnishing supplemental instruction, such as Braille. The itinerant teacher provides all spe-





Left, upper, volunteer mans Brailling machine; middle, migrant children in South Jersey are screened for eye problems; bottom, volunteers sell blind-made products in Mobile Craft bus; above, a textbook is taped for a visually impaired child.

cialized teaching materials. Braille textbooks, tapes, and large print books are ordered from the Commission's Materials and Textbook Center. This is a sizeable undertaking since local school districts tend not to use similar texts. Frequent changes in textbooks add to the problem of producing special materials. And this is where the 300 to 400 volunteers come into the picture.

There are a number of organized Braillist groups throughout the State, some with their own organizational patterns who will do books for our Textbook Center by hand Braille and bind them. Many have thermaform machines which can duplicate Braille. A number of these volunteers are specialists in foreign languages, math, science, and the like. They give up considerable personal time to attend training sessions and lectures sponsored by the National Braille Association, the Commission, and similar groups.

Home Teaching and Home Services. Home teaching for personal adjustment and self-care has been a traditional program for older and homebound blind people. Two to three hundred volunteers are used annually as friendly visitors to minimize the isolation of the homebound person; to help with reading of mail, shopping, and personal needs as well as Brailling of recipes or handwork instructions, transportation to church or for medical attention. The importance of this cannot be overemphasized since a recent study conducted by the agency of 800 older blind persons indicated that 20 percent lived alone and another 20 percent lived in some type of rental or boarding arrangement with nonrelative families. Insight into the needs of blind people is imparted through training by professional staff members. Volunteers are advised not to become involved in professional problems, and to avoid sentimentality and the pitfalls of developing a dependency relationship with the client.

Because of the continuing failure of public transportation or the lack of it in rural and suburban areas, transportation is becoming a major problem to handicapped blind people who should be moving in the community to attend to their personal needs. This same problem increasingly is affecting our workshop population. Public transportation problems which affect the general population adversely have become far more serious for the severely handicapped, the poor, and those whose physical handicap imposes a mobility limitation. Consequently home teaching and other home services become increasingly valuable to the blind population.

Vocational Rehabilitation. The Commission's major thrust in vocational rehabilitation is toward competitive employment. Increasingly, blind people requiring help and coming for service have multiple handicaps. Special programs have been developed leading to greater emphasis on production or sheltered workshops and home industry.

We have enjoyed some success in training blind people to make saleable articles in their home or in small centers. These are generally soft goods items that are woven, hand or machine sewn. It is amazing how many severely handicapped people can operate well an industrial type sewing machine. We even have several deaf-blind clients now working in this area.

Last year the New Jersey Junior Women's Clubs raised funds for a mobile bus whose interior has department store-type counters instead of seats to display and sell high grade articles made by the homebound. In addition to purchasing the vehicle and paying for its adaptation, volunteer groups all over the State were invited to a formal dedication of the vehicle and now help us to make appointments at community fairs, shopping centers, special meetings and the like where the bus is stationed and the sale held. Numbers of local volunteers assist with the sale itself or come to our Home Industry Center to assist

with packaging and pricing articles in preparation for sales.

There are a number of other methods which we employ for selling larger volumes of blind-made articles but the bus program gives us valuable public visibility and frequently encourages local case referrals. Counting all aspects of the home industries program, total annual sales are running at a rate of about $200,000 a year, with something over 200 tc 300 clients involved. We hope to serve as many as 600 people annually in the next few years.

One variation on this theme came from the grass roots. A local Lions Club in the southern portion of the State offered no cost workshop space in its own building because of its interest in unemployed blind people in the Atlantic City area. We now have 8 to 10 machine sewers who use this as a center for production sewing and have one of our staff stationed there for supervision. Insurance is covered by the Lions Club at our request. All production is returned to our central Home Industries Center for processing and sales delivery.

Additionally the local Lions talk to their membership and friends concerning employing blind people or securing contracts for our three packaging and assembly workshops which are in different parts of the State.

Special Projects. The Junior Women's Clubs of New Jersey have a Braille chairman who meets with the director and department heads of the Commission annually to discuss needed projects in any of the Commission's divisions. Those selected by joint agreement are formally voted on by the juniors and become that year's service commitment by Clubs throughout the State. The Mobile Bus for Home Industries was one such major project. They help distribute literature on preventing blindness; they act as casefinders; some get into Brailling and tape duplication groups. Last year each member of the subcommittee of the juniors was asked to secure help from local employers in getting one job placement opportunity for a counselor to evaluate.

The Lions Clubs of New Jersey have been of tremendous help to the Commission. Because of their commitment they are frequently called on for special services. Many of them turn out annually to paint and repair the buildings and cottages at the Commission's summer camp for blind children.

The Telephone Pioneers consist of retired phone company employees. They have adopted a country-wide program of furnishing a repair service for talking books for the blind. These are exceptionally talented and able people who will go out of their way to be helpful. Relations are excellent. Recently they have even used company trucks to pick up large batches of machines to be repaired at their center. Some, however, work out of garage workshops and are equally effective.

Commentary

The use of volunteers is not limited to formalized selection, training, and assignment of volunteers, as attested to by the foregoing. Some of the programs are built upon relationships that develop over the years and are important to the way in which the agency relates to the community.

In New Jersey, volunteers are unpaid and are not considered employees or part of the State merit system. If working, as in the case of Braillists, in a group center of their own, they take care of their own insurance. If on agency premises, they, like any other visitor, are covered by the State which is self-insured. No Workmen's Compensation is involved.

When supplying client transportation, volunteers are expected to furnish liability coverage through their normal automobile insurance. Recently, I asked our insurance broker to investigate the possibility of a "floater" policy that would cover a volunteer who provides transportation, in amounts over normal auto insurance to protect against a major accident. He could find no company that had this type of coverage for a nonemployee. From the volunteer's point of view this could be a very real problem.

We have had no research and demonstration projects to date which involve volunteers. Funding has not been a particular problem. The volunteer program is an integral part of agency function. State funds can be used for training. In addition, the Commission is authorized by law to receive private funds and these can, when authorized by the Commission's Board, be used for volunteer luncheons and awards programs. I do not recall receiving a single request from a volunteer to have personal transportation paid in connection with volunteer work.

The only major problem encountered with the volunteer program has been to keep them regularly busy and to keep them adequately informed. In addition, they have indicated a need to have someone in the agency to turn to in order to deal with their gripes. It was out of this "feed-back" that a supervisor of volunteers was added to Commission staff. ■

COMMENTARY...

. . . On Project Reports

I'd like to express my satisfaction with the *Rehabilitation Record* and, in particular, the Project Reports. However, I do need some information. Just how do we obtain specific reports—through you or by writing directly to the project address?

Gerald T. Cartier
Rehabilitation Counselor
Department of Public Health
San Diego, Calif.

Henceforth, the following legend will appear on the project reports page. It should answer your question: "In some instances recent project reports can be obtained from the grantee. When the report is not available from the grantee, it may be purchased from the National Technical Information Service, Springfield, Virginia 22151. Remittance should accompany orders; prices are $3 for hard cover and $.95 for microfiche copies."

Editor

. . . On Adaptive Devices

The August–September issue of *The Needle's Eye,* a magazine published by Union Special Machine Company in Chicago, published an article regarding an adaptive device enabling those persons disabled in the lower extremities to operate competitively a foot-treadle sewing machine. The device was conceived by Charles Cummings and Willis Brumbaugh, electronics instructors at the Woodrow Wilson Rehabilitation Center. It is inexpensive, easy to attach, and is actuated by flexing of the abdominal muscles against a pressure pad positioned directly in front of the operator and in line with the needle. For information write:

Robert McCullough
Training Unit Supervisor
Woodrow Wilson Rehabilitation Center
Fishersville, Va. 22939

. . . On Homecraft

Adrian Towne received a number of favorable comments on his article "Homecraft: Source of Homebound Employment," *RR,* Sept-Oct 1972 . . . Among others interested in the article was the chairman of the Cerebral Palsy Association board here. She wanted sufficient copies for her entire board, since it had direct application to their work.

John H. Dunn
Public Information Officer
Wisconsin Division of Vocational Rehabilitation

PROJECT REPORTS

In some instances recent project reports can be obtained from the grantee (addresses given below). When the report is not available from the grantee, it may be purchased from the National Technical Information Service, Springfield, Virginia 22151. Remittances should accompany orders; prices are $3 for hard cover and $.95 for microfiche copies.

A SCALE FOR TESTING SPEECH DISCRIMINATION. (RD 55197) Wayne State University, Department of Audiology, 261 Mack Blvd., Detroit, Mich. 48202. 59 pages.

A PROGRAM TO IDENTIFY THE FACTORS INVOLVED IN THE REHABILITATION OF PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASES — A MULTI-DISCIPLINARY STUDY OF 140 CASES. (RD 2517) Regional Chest Center, University of Nebraska Medical Center, 42nd and Dewey Ave., Omaha, Nebr. 68105. 163 pages.

REGIONAL MAXILLOFACIAL PROSTHETIC REHABILITATION CENTER. (RD 55194) Mayo Foundation, Rochester, Minn. 55901. 79 pages.

DEMONSTRATING HOW A REHABILITATION CENTER CAN REDUCE COMMUNITY BARRIERS TO EMPLOYMENT OF EPILEPTICS. (RD 2682) Springfield Goodwill Industries, Inc., 285 Dorset St., Springfield, Mass. 01108. 188 pages.

SOME INFLUENCES OF FAMILY GROUP THERAPY ON THE REHABILITATION POTENTIAL OF CLIENTS (RD 55223) Delgado Junior College, Rehabilitation Department, 615 City Park Ave., New Orleans, La. 70119. 109 pages.

BUILDING A NETWORK OF SERVICES: 1963–1971 — GREATER CLEVELAND MENTAL RETARDATION DEVELOPMENT PROJECT. (RD 1769) The Welfare Federation of Cleveland, 1001 Huron Rd., Cleveland, Ohio 44115. 287 pages.

MEANWHILE—AT HOME—A STUDY OF MENTALLY ILL VOCATIONAL REHABILITATION CLIENTS, 55 pages, and PART TWO SUPPLEMENTARY REPORT, 49 pages. (RD 1555) Department of Rehabilitation, Research and Statistics Section, 714 P St., Sacramento, Calif. 95814.

IDENTIFICATION AND EVALUATION OF DISABILITIES OF LEPROSY PATIENTS IN TEXAS AND UTILIZATION OF VOCATIONAL REHABILITATION SERVICES. (RD 3016) Texas State Department of Health, 1100 West 49th St., Austin, Tex. 78756. 31 pages.

(*Continued on page 31*)

We all have heard the adage that water seeks its own level. Analogous to this physical phenomenon in the social sphere is the precept that as a body of knowledge and a group of techniques surround an area of service or whatever, the area settles down to a "business as usual" mode of operation. Time evens out the flow. Soon the body is quiescent. An occasional ripple of controversy ruffles the surface but, by and large, things go on as before in an "approved" and "accepted" progression.

Continuing the analogy, as a flood disrupts the old level of water, rhetoric becomes a catalyst that raises mundane issues (the ripples) into higher visibility. . . .

We have heard many of the issues contained in the following papers raised in conversations (not quite so spectacularly, however). We recognized them as opinion, and we recognized opinion as a healthy aspect in and for our field of endeavor. Opinion is offered here as just that. We have requested reactions from selected persons in the field of rehabilitation. We felt that they could address themselves to these points with candor and with wisdom.

Persons in the field of rehabilitation rely heavily on evaluation, as we look at programs for cost effectiveness, study client outcome through followup, and institute research studies to better hone the sharp edge of service delivery: agencies reorganize for efficiency, supervisors realign their people for better delivery, and people look at each other and at themselves to establish working and workable priorities. We hope that the following pages will "raise the level" of thinking in these matters and that the level will "overflow" onto letters so that the "high water mark" can be observed by others in the pages of future editions of the *Record*.

Our course depends on "deep water." Are the questions raised here the shoals that we must avoid or circumnavigate? ■

Six Scandals In Vocational Rehabilitation

Simon Olshansky

Vocational rehabilitation leaders in State and federal agencies still continue to talk much better than they perform. They still continue to tolerate practices which should not be tolerated.

In this paper I shall discuss six practices which I shall call scandals, as their uncritical acceptance for so many years justifies the label scandalous. Every system has it imperfections. Not to recognize these inevitable imperfections is certain to perpetuate them. In vocational rehabilitation, the habit has been to pretend that there are no imperfections or, if there are, that they are minor, to be remedied by dosages of more money. While more money would be helpful, more helpful would be more thought and more candor.

It should be noted that the sequence of stated scandals is not intended as an order of valuations with the first being the most important and the last the least important.

Lack of Supervision

The first scandal is the lack of real supervision, of the kind which would guide the counselor while protecting the client. At present, the counselor receives little or no guidance and the client receives little or no protection. Most significantly, relative to the client, the counselor exercises almost absolute power. As long as he dots his "i's" and crosses his "t's," the counselor can do almost anything, restrained only by his uneasy and undependable conscience.

Who gets services—the kind, amount, and quality all are a matter of potluck. If the client is lucky, he may get good service tailored to his needs. If he is unlucky, he may get no service or the wrong kind. Moreover, DVR agencies generally fail to carry out the compelling ethic that if they do not help someone, at least they do him no harm. How many clients have been hurt, we shall never know. But we do know that it is wrong to shut our eyes to the danger that we may be inflicting harm, innocently or maliciously, on some clients. How can we blindly and blandly continue to tolerate this intolerable condition?

Some leaders will point out that counselors have to get experience and in the process some clients might be hurt. While this may explain some of the practice, it does not justify it. Clients have not been put on this earth to be practiced on by counselors.

Exclusion of Counselors

The second scandal is the exclusion of counselors from policy-making decisions. They are told that they are the key men and women in the program, but rarely are they invited to participate in any policy-making decisions. If policies and practices are to be significantly improved, they should be reviewed by counselors whose experiences give them some insights leaders do not always or often have. Moreover, if they are to perform more effectively, they should have the feeling of being a part of, not apart from, the agency.

Too many feel as workers on a bureaucratic beltline turning out "rehabs" for their remote leaders. If counselors are to manifest better feelings toward clients, they have to develop better feelings toward themselves. The need for including counselors in policy-making decisions is so obvious, the wonder is that it has not been done. Why?

Exclusion of Disabled

The third scandal is the exclusion of the disabled from participation in program planning and review.

No matter how imaginative and sympathetic professionals may be, they still do not have the kinds and qualities of experiences undergone by the disabled. Since each day they live their problems, their views should be sought, not just as a goodwill gesture or as a reluctant concession, but in order to enrich the leaders' understanding of rehabilitation problems. How can professionals be-

Mr. Olshansky is Executive Director, Community Workshops, Inc., Boston, Mass. This article is based on a paper that he presented at the Region I meeting of the National Rehabilitation Association, Kerhonkson, New York, on June 8, 1972.

gin to appreciate the program's limitations unless the disabled are brought in as participants? How can we consider innovations without considering the views of the disabled?

Too long the disabled have been treated as "gooks" accepted as long as they behaved themselves in conformity with DVR's expectations. It is high time we treated them as human beings.

It should be stated that until the disabled are involved in program planning the suspicion will persist, with good reason, that the vocational rehabilitation program fits the needs of professionals better than the needs of clients.

Neglect of Terminal Needs

The fourth scandal is the failure to provide for the terminal needs of those clients who cannot compete in the regular labor market.

If disabled persons and counselors had been involved in program planning, it is doubtful that this need would have been overlooked for so long. Many leaders remote from the disabled just do not begin to appreciate the urgency of this need for extended services. To exclude so many clients from such services and to compel them to vegetate in isolation is a cruelty which reflects little credit on our humaneness and our intelligence.

It is encouraging to report that some administrators are beginning to recognize this problem of extended employment and are beginning to take steps to deal with it. But there is little evidence that meeting this problem has been assigned as high a priority as the facts would warrant. Still much too much attention and money are devoted to transitional services with the inevitable and continuing neglect of the clients who need terminal services.

Overselling of Counseling

The fifth scandal is the overselling of counseling.* It should be recognized that one of the American pathologies is the tendency and habit of overselling, whether it is of science, technology, or of rehabilitation. We are reluctant to be modest about our capacities to achieve selected goals, and are unwilling to recognize obvious limitations in our skills and knowledge.

Counselors following the unhappy traditions of social work and psychiatry have proceeded to tell everyone how effective counseling is in solving vocational rehabilitation problems. Whether the oversell is to persuade counselors or clients of their worth is not clear. But what is clear is that like many sellers they are unwilling to let the product sell itself. It appears that counselors have all the right answers to the wrong questions.

Many counselors, like social workers and psychiatrists and unlike physical scientists, are unwilling to examine their guiding theory to see if it is valid, for whom, and under what circumstances. In the physical sciences, if a theory over time does not work, scientists begin to suspect the theory; they just do not continue to gather more data and continue to defend it frantically and fanatically. In counseling, counselors continue to suggest that the fault is always with the practice, not with the theory. What is needed, they say, is more time to practice their skills guided by their unassailable and unexamined theory.

It is high time counselors pause to review carefully their theory. It is late, but not too late, to recognize that every theory is a limited understanding, opening and closing possibilities. Some possibilities cannot be tested out which are excluded by

*This scandal does not involve the leaders as much as it does the counselors and their university progenitors.

the guiding theory. For example, the impact of work in altering behavior and in producing insights may not be considered since part of the theory observed by many counselors is that behavior change and insight must precede work adjustment. How can one prove the validity of the first sequence (work producing change) if one's theory precludes the testing of that possibility?

In any case, counselors should stop their oversell and rely more on showing the fruits of their efforts rather than the boasts of their professional eagerness. In addition, they should develop a much better sense of their limits than they have demonstrated so far.

The Closure Mystique

The final scandal is the "closure mystique." A case is closed *rehabilitated* and everyone is supposed to rest proudly on the basis of this final act. The assumption is that the person whose case is closed is happily and eternally rehabilitated.

For some clients this assumption may be correct. For other clients the assumption is based on either ignorance or innocence or, if one wants to be candid or cynical, on fraud.

As an example, almost everyone knows that many schizophrenics are not going to stay rehabilitated for very long. Throughout any year many of them will require additional help as a result of regression and/or hospitalization. Why is it not more sensible to recognize and accept the reality of their chronic vulnerability and continue to serve them as necessary without engaging in deceptive closures?

Moreover, the "closure mystique" creates within DVR agencies an atmosphere of canny caution and calculating carefulness which frequently makes the rehabilitation process an impoverishing and constricting experience rather than an enriching and expanding one for all participants.

Vocational rehabilitation is a humane transaction. In the agencies' blinding and tenacious obsession with closures, it has become less humane. It has often become a legalistic and bureaucratic scramble, meeting the needs of neither many counselors nor of many clients. For some counselors and clients vocational rehabilitation has become a never-ending nightmare of frustrations and resentments.

An Afterthought

A seventh scandal may be added as an afterthought. In 10 years some professional will write a paper called *Seven Scandals*, repeating the six herein stated. He will add a seventh scandal which is that so little had been done to deal with the original six.

Shall we permit scandal number seven to occur? ■

RESPONSE

An Administrator's View

Craig Mills

In his usual pungent manner, Mr. Olshansky has used colorful, emotional language to dramatize six problem areas in rehabilitation. In order to make his point, he used the term "scandal" and laid the blame at the feet of the "leaders in State and federal agencies." He is too astute an observer of the rehabilitation scene to believe this himself. At the risk of sounding defensive, I would be perfectly willing to share the blame for these problems with workshop and facility people, doctors, lawyers, industry, labor, psychologists, legislators, governors, congressmen, budget officers, and a few others. For I have enough confidence in the sincerity and dedication of the State and federal leaders that I know, that if all of Mr. Olshansky's scandals were true and if it were in the power of State and federal leaders alone to correct them we would see substantial changes.

One usually associates a scandal with dishonesty, immorality, or illegality of such proportions as to be offensive and disgraceful to respectable people. If this is what he means, then the author should have used the title of the "Six Slanders in Vocational Rehabilitation." Without being very specific or factual, he has slandered the rehabilitation leadership with his broad-brush accusations. Such irresponsible criticism seldom corrects the offenses alleged and discredits the work and worth of honest leaders.

But one must read this cantankerous author with tongue-in-cheek and a bit of wry humor as he uses emotionally toned words in an "overkill" effort to make some points that may have a measure of truth and

Mr. Mills is Director, Division of Vocational Rehabilitation, Florida.

may be important to rehabilitation. Let's consider each one briefly:

Lack of Supervision. This is a known problem area. It would be more honest and less scandalous to admit that federal and State leaders have long recognized the problem and have worked toward solutions. When Joseph Hunt was Deputy Commissioner to Miss Mary Switzer of VRA, he referred to inadequate supervision as the "soft underbelly of VR," and he helped to promote training grants for institutes on supervision. VRA promoted the program administrative reviews (PAR studies) to help improve the quality of casework and supervision in the rehabilitation process. Some States have moved to set up a ratio of one supervisor for every five to seven counselors. Some States have not been able to get legislative support for supervisory positions, but they have been in there fighting for them.

State and federal leaders have been active in the creation of the Administrative and Supervisory Practices Division of NRA and have helped to organize State chapters.

RSA has funded inservice training programs in supervision and regional offices have supported short term training in supervision.

We would all agree that more emphasis is needed on supervision, and we would support more training of supervisors and more supervisory positions. But for the author to imply that countrywide there is now such a lack of supervisors to the point that counselors are callously practicing on clients and that this is done with the knowledge and approved neglect of their leaders is simply not true. I would say to the author as Miss Mary Switzer once said to an SRS official, "You need to get out and visit some rehabilitation programs."

Exclusion of Counselors. It is difficult to make the switch with the author from indicting counselors for damaging clients and then to insist that they should be given policy-making and decision-making authority. Most leaders have more confidence in their counselors and welcome their participation in policy and decisions. Increasingly this is done through counselor advisory committees, the preparation of counselor manuals and policy manuals, the establishment of agency priorities, the preparation of legislative budgets, revision of State VR laws, and a host of other matters of importance to clients as well as counselors. Responsible counselors have moved beyond the gripes on salaries, travel, and personnel procedures which are usually controlled by the legislature or State merit system.

It is true that most States could do more to involve counselors. Here the author has an excellent point. But, again, it is dishonest journalism to say that counselors have been totally excluded by all leaders to the extent that it can be labeled a scandal.

Exclusion of the Disabled. This criticism is well founded in terms of lack of involvement of disabled people in the past. But I cannot agree that this was a planned exclusion of the scandalous proportions described. It would be helpful to know how the author has solved this problem in his agency.

Most State and federal programs have opened employment in the agency to handicapped people, and many have sought the participation of the disabled on advisory committees, statewide planning, and projects. The federal agency requires this of States. Perhaps it should be a requirement for facilities who receive grants or serve VR clients.

Some States have found it helpful to pay expenses for disabled people to ensure their participation. Individuals are needed as well as organized groups.

While there may be isolated incidents of unfair treatment of clients, this is not condoned by the leadership in VR and the author knows this. His comment that "the disabled have been treated as 'gooks'—and it is high time we treated them as human beings" is pure slander of the vast majority of the humane and dedicated people in vocational rehabilitation. It is not necessary to resort to such accusations to make the valid point of the need for greater participation by the disabled.

Neglect of Terminal Needs. The author never clearly identifies the problem nor indicates the solution he desires. But apparently he refers to the needs of those severely disabled people who may not be "transitional" clients who move on to competitive employment. Such clients have many needs inadequately covered by the negative term "terminal." The field of rehabilitation, including NRA, as well as State and federal leaders in VR clearly recognizes the need for a program of rehabilitation for self care which will not require full employment as a basis of eligibility for vocational rehabilitation. This is covered in the Vocational Rehabilitation Act of 1972. There is increasing support each year for some system of subsidy to long term workshop employees who cannot achieve a minimum wage, and there is support for some basis of subsidy to the workshops who provide for them. There is increasing support for housing and transportation costs for the severely disabled.

The author's scandal may be a fair indictment of the country as a whole. But it leaves the impression that State and federal leaders have maliciously avoided serving this group or recognizing their needs. Again this is dishonest journalism and an incomplete statement of the facts.

Overselling of Counseling. The author indicates that "this scandal does not involve the leaders so much as it does the counselors and their university progenitors." On this basis one wonders why he left it among his six indictments of the

State and federal leaders. The author does not make it clear what the "guiding theory" problem is.

Since the 1950's rehabilitation counseling has moved far beyond the junior grade therapist problems. Some few counselors from some institutions may still regard themselves as therapists and counseling as a substitute for all else in the rehabilitation process. But this is not characteristic of the new breed of hard working rehabilitation counselors coming from the graduate programs. They have no illusions that "behavior change and insight must precede work adjustment." They have learned through field experience to use the techniques of work evaluation and behavior modification along with all the rest of the counseling skills.

I would agree to caution in overselling counseling in the rehabilitation process. But I would insist that disabled people deserve the right to high quality counseling as much as they do quality medical care, quality training or any other rehabilitation service.

The Closure Mystique. Nearly everyone in rehabilitation recognizes that there are some problems in the case closure procedures. As the author cites in his example of the schizophrenic case, there are many severely handicapped people who may need repeated services or lifetime services by rehabilitation or some agency. For such, a different coding system or standards of closure may need to be devised.

But as long as VR operates under State and federal laws and uses State and federal funds, some system of reporting and accountability can be expected.

Many States now have elaborate data processing systems which give extensive details on cases in every service status and every type of disability being served. They are able to give legislators far more information than simply closures. It is unfortunate that RSA has not been able to get funds for such a national system to use with the Congress. A balanced system of reporting might take some of the emphasis off closures. Until that time comes, there will continue to be a need to report the achievements of the rehabilitation goal for disabled people whether it be full employment or substantial improvement for those who cannot achieve full employment as provided in the new amendments. This can be done fairly and with full consideration for the human needs and the right of handicapped people. Without any fraud or deceit or any "tenacious obsession with closures." ■

RESPONSE

A Counselor's View

Gary J. George

Having recently served as a rehabilitation counselor for over 6 years, I appreciate Mr. Olshansky's straightforward style, and I admire his uncanny ability to isolate and simply describe the practices in State and federal agencies. He aptly demonstrates the basic approach that humanistic psychologists would call taoistic objectivity. This approach stresses noninterfering observation rather than controlling manipulation; it means asking rather than telling—the opposite of molding, propagandizing, or teaching. It is what a good counselor does with his client by trying to get him to see what is inside him, where it has taken him, where he might be going, to wit, what is good for him rather than what is good for the counselor or his agency.

I believe that a greater perspicuity, a greater accuracy of perception of a reality outside of ourselves comes from a loving perception, such as Mr. Olshansky's. The kind of love one has for his work produces great interest, even fascination, and, therefore, great patience with long hours of observation. It leaves one with the feeling of being unafraid to unfold, to open up, to drop defenses; in essence, to be unafraid to be what "is."

What a truly remarkable and wonderful event it would be if suddenly all of us in the field could forget our personal involvements and political entanglements and become completely objective, nonthreatening, and unafraid, scrutable [sic]; imagine the good that could be done for rehabilitation as it relates to its stated goals; oh, yes . . . But, while this is an ambitious and worthwhile position for any profession to want to develop, no beautiful program or constitution or law will be of any consequence unless the people become involved,

Mr. George is Project Director for Evaluation and Psychologist, Lincoln (Nebraska) Goodwill Industries.

and strong, and healthy, and good enough to want to put into practice the right things in the right way.

In reality, however, there are key persons in many organizations who impede progress. They have been described by C. Northcote Parkinson as being infected with enjelititus, a bureaucratic disease. In some unconscious realization that they have taken a job beyond their abilities—the Peter Principle—they save face by becoming super organization people, loaded with statistics and procedure and looking to lose personal identity in the system. While it is conjectured that these people attract and support each other, it has been demonstrated by social psychologists that what a person is or does to some extent depends upon the institutional arrangement in which he finds himself.

The key here is what Ruth Benedict calls social synergy, that trend in social arrangements that transcends the dichotomy between selfishness and unselfishness. For example, it is one thing to define the good counselor as one who helps the most needy clients or becomes involved with the most needy causes. It is quite another to define him as one who knows his rules and doesn't make mistakes and thereby earns a promotion to supervisor.

Set in this philosophical framework, Mr. Olshansky's six scandals can be seen as interrelated. That is, if one assumes that the social synergy of these State and federal organizations is authoritarian and bureaucratic, then the problems are simply related. The rehabilitation process must necessarily fit the needs of the organization more than the needs of the client just because it is a process and not a living concept. The program must have order; it must have rule; it must have accountability; it must be uniform. It must have a way to measure its pulse in dollars and cents because dollars and cents are its life blood. So the closure rehabilitated is important as a measure of success. Success is important to the maintenance and growth of the program. You can't have counselors making administrative policies because they mess up neat line policies and bring up failures and are always wanting things for clients that are impossible

RESPONSE

An Educator's View

Kenneth W. Hylbert, D.Ed.

Olshansky tells us that the fifth scandal in vocational rehabilitation is the overselling of counseling. While it might seem that counselor educators should take offense, I find myself in at least partial agreement. I doubt, however, that counseling is oversold as an approach to the solution of client problems when it is appropriate to the needs of clients who can profit by the approach in situations which warrant. When counseling is inappropriate it should not be provided! I disagree that the scandal does not involve leaders in the field. These leaders certainly bear some responsibility for the climate in which overselling occurs.

Perhaps I am really addressing myself to a related scandal—that of utilizing professionally prepared counselors for a multiplicity of duties which often are not even closely related to counseling and which do not require advanced degree preparation in counseling in order to be performed adequately. This might be referred to as Scandal 5A.

Some 18 years ago the then Office of Vocational Rehabilitation sponsored and funded graduate programs in rehabilitation counseling. Approximately 90 of these programs have been initiated. Most of them are from 1½ to 2 academic years in duration and emphasize counseling theory and techniques. Initially it was hoped that they might serve as a solution to the acute counseling manpower shortages which would inevitably arise with the expansion of the State-federal programs following the passage of PL 565 of 1954.

The record has not been particularly reassuring. Even such knowledgeable observers of the passing scene as E. B. Whitten have suggested that graduate programs are endangered because they have not measured up to initial expectations.[1] Although nearly 80 percent of all rehabilitation counselors are employed in the State-federal programs, recent RSA reports indicate that less than one-third of the graduates seek employment in these settings. Furthermore, the turnover is fairly high and, in some instances, exceeds three-fourths over a 3-year period.[2]

Perhaps the problem is in part related to the overselling of counselors, if not counseling. In point of fact shortages of counselors may not presently be as acute as is sometimes supposed. Rather, it may be that counselors are being underutilized

Dr. Hylbert is Director, Rehabilitation Education Programs, The Pennsylvania State University.

or difficult. Clients likewise are always complaining, wanting things they are not supposed to get. They just don't understand administrative techniques and budgets! The supervisors are the first line of defense against this "chaos" and should try to keep order and bring back any information relative to breaking of any rules which break down the order. Change of procedure is disruptive and so should be resisted. The process is mechanistic because that is scientific; science is order.

Purposely I have overstated the point slightly to make it clear. But make no mistake, I believe that the end goal of rehabilitation is often antagonistic to most State and federal rehabilitation programs. The system is not humanistic; fear of being human and of making a mistake is rampant; escape from freedom into hierarchic rule is growing. Once this philosophy pervades an organization, the newer people brought into it must already fit the philosophy or be made to fit it so as not to pose any threat to the stability of the status quo. So it grows.

One way out of the whole mess and back to an open and honest appraisal of the process, as Mr. Olshansky suggests, is to change the social synergy of the organization. Make counselors want to do a good job; give them more voice in policy-making decisions; let them be client advocates. Innovation and change should be rewarded; incentives for work should be greater. But, the key is to relieve administrators and most supervisors from the responsibility of hiring and firing personnel; they are incapable, for the most part, in choosing personnel for humanistic reasons. Let a senior counselor or small group of counselors pick their fellow workers, and let them state their reasons for doing so. Imagine the benefits of an applicant being able to ask questions about the supervisor or organization and getting a straight answer! Change the social synergy to a more positive and humanistic one and you can have your organization and rules and still be humanistic.

Space limitations have required an abbreviating of these remarks. The question of "overselling of counseling" therefore must await a later opportunity. ■

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or, at best, inappropriately utilized. Surveys have shown that in some instances counselors may be involved in client contact as little as 20 percent of their working time. We might suppose that much of this contact time is not counseling time by any generally accepted definition.

We have a contradiction of sorts here. Or do we? Olshansky believes counseling is oversold and to the extent that counseling provided is inappropriate or is not a client need one can only agree. On the other hand there is some evidence that many so-called counselors really do little counseling. Thus, it is small wonder that professionally prepared counselors are sufficiently disenchanted with the lack of opportunity to utilize their counseling skills that they either avoid employment in agencies which, they have heard, except little from their skills; or they leave employment with such agencies when the moment of truth is upon them.

Now it may be argued, and sometimes it is, that the focus in graduate education is wrong. Some people say that since coordinative, case management functions constitute such a large portion of the so-called counselor's responsibility, the counseling content of graduate programs should be deemphasized in accord with the realities of practice. Certainly the expectations of graduates might be altered and, therefore, more readily met. But the danger lies in the possibility that clients who do need vocational rehabilitation counseling in depth will not receive the appropriate quantity or quality.

Perhaps the better solution is not to deemphasize the rehabilitation *counseling* content in graduate education but rather to pursue with greater vigor the concept of divisions of labor which will provide the opportunity for professionally prepared counselors to spend most of their time counseling, or in the performance of related duties requiring expertise justifying graduate study.

As we serve more of the hard-core handicapped, including the severely physically disabled, the emotionally disturbed, the alcoholic, the drug addict, the public offender, etc., the needs for qualified counselors to provide indepth counseling will probably increase substantially rather than decrease. It will become imperative that we conserve rehabilitation counseling manpower in every legitimate way. As Olshansky has so effectively pointed out, we certainly need to reexamine our theories to the end that the amount and kind of counseling become more appropriate to client need. When no counseling or relatively less counseling is needed this should be faced realistically and a correspondingly greater responsibility for meeting client need should be given over to coordinators (case managers) and aides. A detailed rationale has been developed elsewhere.[3,4]

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RESPONSE

A Researcher's View

George N. Wright, Ph.D.

Realistically the world needs dissenters to spotlight its ills, which include such evil advents of civilization as foolish wars, overpopulation, destruction of natural resources and wildlife, and pollution of its life-supporting environment. Mr. Simon Olshansky has elected to become the number one dissenter in vocational rehabilitation.

But to dissent from rehabilitation is not the same as to speak out against wars and destruction. Rehabilitation is a constructive human concept. The State-federal VR program deserves constructive criticism. Indeed, the system must continue to improve because its support in serving millions of handicapped Americans is the public tax dollar.

Mr. Olshansky makes a great case for "treating clients as human beings," but he presents neither research evidence nor even personal knowledge of what is actually taking place outside his confined bailiwick of observation. In a book on the rehabilitation of persons with epilepsy that I am editing, the point is made over and over that the rehabilitationists must work together with the client. Also, my Institute right now is conducting research on basic client needs—by asking clients—so that the rehabilitation process can be centered around these needs.

Dr. Wright is Professor, Rehabilitation Counselor Education and Director, Rehabilitation Research Institute, The University of Wisconsin, Madison.

Mr. Olshansky attacks closures resulting from the acceptance of those clients who do not need the long term treatment of rehabilitation facilities but can achieve rehabilitation through short term and inexpensive State agency services. As a State DVR counselor for 10 years with a caseload of up to 130 closures a year, I learned that a little effort and a little money frequently results in great benefit to "easy cases" who become quickly rehabilitated but might never adjust without this small amount of help. The idea of "preventive rehabilitation" is not new: practical rehabilitationists have long accepted the wisdom of extending services to the somewhat disabled high school student who, without them, would soon go into a destructive spiral of underemployment, rejection, and deteriorating potential. So why knock the VR counselor, the rehabilitation process, or its highly positive record with such emotionally derogatory phrases as "deceptive closures"?

The author makes broad, sweeping attacks that indite rehabilitation counselors as calloused and unprofessional. He says that the counselor has an "undependable conscience," that he "exercises almost absolute power," that he practices his skills on clients, that he excludes clients "from participation in program planning and review," that who gets services is "a matter of potluck," and on and on. In his obsession with the "closure mystique," he ignores the fact that, as Alfred Slicer pointed out, "there is nothing incompatible between quantity and quality" in rehabilitation counselor closures. Such trite phrases as the "closure mystique" obscure the basic truths: every rehabilitation closure is a real live person who is certified as handicapped and has had helpful assistance.

If you twist concepts and carefully choose positive words, you get people nodding their heads "yes." (There is a simple safeguard against being stampeded by such word artists: ask yourself if anyone would disagree with an opposite statement.) The danger to the reader in such persuasive techniques is that misinformation is successfully slipped in between the lines. I think this is the essence of this article's destructiveness to an increasingly constructive process called vocational rehabilitation.

It is clear that I resent the negativism expressed in this article. I prefer to look at the situation from the positive side, to, as the popular phrase goes, "accentuate the positive, deemphasize the negative." Let me give you an example of this better way of looking at things in one area, the improvement of rehabilitation counselor education programs. Five major, national rehabilitation organizations (NRCA, ARCA, CRCE, CSAVR, IARF) have joined together to form a Council On Rehabilitation Education (CORE) to develop criteria and help improve graduate rehabilitation counseling programs all over the nation. A substantial federal grant will finance the first 5 years. My Institute instigated this project and is conducting the research. I am personally proud of this because it is the constructive route for objectively identifying needs and then doing something about them in an organized manner.

In short, I am disappointed that Mr. Simon Olshansky is not supportive and constructive with re-

gard to vocational rehabilitation as a process, an agency, and a profession. In reading the manuscript, I was struck by the lack of documentation of opinions—from research, the literature, agency policies and operations, and public law. In a sense, Mr. Olshansky is the one who is creating a "scandal." It is not, as he defines the word, uncritical acceptance of bad practices, but purposeful disgrace, defamation, and injury. The State-Federal VR system is critical of itself and is always improving practices. Professional people in rehabilitation can help by offering constructive criticism. ■

Project Reports

(*Continued from page 21*)

A DEPENDENCY REDUCTION—"DO IT YOURSELVES KIT," NO. 1. DEPENDENCY AND THE POOR, 67 pages; NO. 2. THE COMMUNITY RESOURCES INSTITUTE—A PROCESS FOR ATTITUDE CHANGE, 58 pages; and NO. 3. COMMUNITY SPECIALISTS IN REHABILITATION AND COMMUNITY SERVICES PLANNING FOR THE REDUCTION OF DEPENDENCY, 159 pages. (RD 55271) University of Arizona, Rehabilitation Center, Tucson, 85721.

ADVANCES IN CLOSED CIRCUIT TV SYSTEMS FOR THE PARTIALLY SIGHTED. (RD 55285) Rand Corporation, 1700 Main St., Santa Monica, Calif. 90406. 88 pages.

DEPENDENCY AND ITS IMPLICATIONS FOR REHABILITATION. (RD 55011) Northeastern University, New England Rehabilitation Research Institute, Boston, Mass. 02115. 139 pages.

RUBELLA—AN ABSTRACT REVIEW OF SELECTED MATERIALS FROM THE WORLDWIDE EDUCATIONAL, MEDICAL, SOCIAL, AND REHABILITATION LITERATURE. (RD 55066) Excerpta Medica Foundation, 228 Alexander St., Princeton, N.J. 08540. 368 pages.

Accreditation For Rehabilitation Counselor Education Programs

The Council On Rehabilitation Education (CORE) is developing a mechanism for the accreditation of the nearly 70 master's level RCE programs in U.S. colleges and universities. The philosophy behind the accreditation effort is not to censure programs but to facilitate *improvement and refinement.* A unique feature will be a technical assistance component for developing programs.

CORE is a nonprofit organization composed of representatives from each of the five main professional associations concerned with rehabilitation counseling. The membership includes two professionals each from ARCA, NRCA, CRCE, IARF, and CSAVR. CORE is receiving funds from the RSA for the development period, which will extend over 5 years. During this time, CORE will ask for input from RCE program students and former students, graduates, employers of graduates, and, of course, from the coordinators and the faculties of the RCE programs.

All RCE training programs, whether federally funded or not, are encouraged to participate in conceptualizing the program self-assessment instrumentation and in developing standards. *If your program has not been contacted yet, please call the University of Wisconsin-Madison Regional Rehabilitation Research Institute at (608) 262–4354.* The Institute is working with CORE on the research phase of the project. ■

HEMOPHILIA AND THE REGIONAL CENTER CONCEPT. (RD 2522) Orthopaedic Hospital, 2400 South Flower St., Los Angeles, Calif. 90007. 79 pages.

OBSERVER AGREEMENT FOR THE EVALUATION OF STUTTERING SEVERITY. (RD 1721) Case Western Reserve University, 2040 Adelbert Rd., Cleveland, Ohio 44106. 60 pages.

MULTIPLE FAMILY THERAPY OF MENTAL PATIENTS. (RD 55309) Research Foundation for Mental Hygiene, Creedmoor State Hospital, 80–45 Winchester Blvd., Jamaica, N.Y. 11427. 118 pages.

"INTO THE MAINSTREAM: BRIDGING THE GAP BETWEEN DISADVANTAGED YOUTH AND OTHER YOUTH IN THE WASHINGTON METROPOLITAN AREA." (RD 55082) National Conference of Christians and Jews, 735 Southern Bldg., 1425 H St. N.W., Washington, D.C. 20005. 24 pages.

INTENSIVE REHABILITATION EFFORTS TOWARD TOTAL FAMILY MEMBERS IN TWO CHARACTERISTICALLY DIFFERENT MODEL CITY AREAS. (RD 55019) Rhode Island State Department of Education, Division of Vocational Rehabilitation, Gardner Bldg., 40 Fountain St., Providence, R.I. 02903. 44 pages.

BIOPHYSICAL EVALUATION OF HEALING BONE. (RD 55078) Georgetown University Medical Center, 3800 Reservoir Rd., N.W., Washington, D.C. 20007. 39 pages.

BRAILLE CODES PILOT PROJECT. (RD 55094) American Printing House for the Blind, 1839 Frankfort Ave., Louisville, Ky. 40206. 139 pages.

LEVEL OF ABSTRACTION OF DISAGREEMENTS AS A DETERMINANT OF CROSS-CULTURAL INTERPERSONAL PERCEPTION. (RD 55175) Department of Psychology, University of Illinois at Urbana-Champaign, Champaign, Ill. 61820. 75 pages.

(*Continued on page 35*)

Building Houses; Building Skills

Ron Bourgea

Recently, I took a short trip to Smock, Pa., to have a look at a unique project involving a community organization and a special education program.

After that trip I felt compelled to find some kind of symbolism in it. I reasoned that many other trips that I had heard about to exotic places for renowned purposes were really important because they were national and international gatherings of the very important people who direct the very important businesses of rehabilitation.

But where did that leave Smock, Pa.? It left it at the grass roots where, I found, very important people were struggling with this thing called "life." They were trying, as man has for centuries, to fill up the container to the brim with meaning and with purpose. I really saw the symbolism, the principle: life processes start from what may seem, at a casual glance, to be the insignificant—the human being from two microscopic cells, the oak from the acorn. To wit, the "big" things in life owe their maturity to the thousands of little struggles that are won in unobserved arenas.

The big things in Smock in the past were the mines from which the local people earned their living. Now the inactive coal tipples (elevators) are all that remain of that bygone era. They stand as ghostly and mute landmarks in the maze of small patch towns that dot the hilly, Western Pennsylvania countryside. Among them Smock stands the same as the others, yet, it stands a little different because of the "marriage" of two organizations who are concerned for the welfare of the geographical area and of its people. The marriage took place in 1971 when a group called Concerned of Pennsylvania, Incorporated (CPI) and the State Department of Education's special education section of Intermediate Unit One (IU–1) joined forces in a vocational education project for educable mentally retarded high school students who rehabilitate dilapidated homes and build new ones for at-cost resale to low-income families.

To date four old homes have been renovated and are occupied; one new home has been completed and is about to be purchased, and four more are under construction. The old, abandoned homes are bought for taxes by CPI as is the land upon which the new homes are built. Because of this savings and the absence of labor charges, the houses are sold for materials cost—two renovated homes sold for $5,000; the highest priced home went for $9,500.

The new homes, of course, are more expensive. In this case a new dimension is added by the purchase of ready-made house shells, sold by a local prefabrication company. The purchase helps bring money and work into an area in which unem-

Mr. Bourgea is editor of the Rehabilitation Record.

ployment is several percentage points higher than the national average. Once the shell is erected, the students from IU–1 go to work installing heating and plumbing, finishing walls, floors, and stairs, installing windows and doors, and accomplishing all the other tasks that go into the finished product.

Depending upon the condition of the house, the students perform all of the necessary work needed to make it habitable. I visited one such home and saw, next to it, another that stood in its original shabbiness. The project house had been stripped to the studding and rebuilt from there. In contrast to its neighbor's ailing clapboard siding, the renovated house's exterior walls were shingled in soft green asbestos. The interior was light and airy, with the living room, dining room, and three upstairs bedrooms completely paneled. A fourth, unfinished upstairs room allows for future expansion. IU–1's students had installed new wiring, a new heating system, and "brought in" the plumbing. The *house* now was a *home* for a young married couple who have two children. "I am happy with our home," the lady of the house testified.

Since this program is considered a senior high school project, students selected come from that age group. They are, essentially, educable mentally retarded persons who have been referred by school counselors, psychologists, or teachers. Sometimes referral comes from the student himself. Since the program has gained more visibility, more referrals are coming from parents. Before a final selection is made, parents are contacted, and the program and its significance to the student are discussed. But even after selection, a student may transfer out of the program without penalty or being "held back" from graduation.

Students First

The fact is never overlooked that the young, mentally retarded persons who work on these projects are first of all students. Their academic work progresses hand-in-glove with their construction tasks. These are made relative through close cooperation between the vocational teacher and the special education teacher who are physically located at the construction sites with the student workers.

The problem of distance between construction site and school was corrected by providing a trailer at the building location where academics are imparted to the students. This also enabled the project director to raise the number of students from 10 to as many as 24. Half the student body attends trailer classes in the morning and works on the houses in the afternoon. The other half alternate, with morning workers attending classes in the afternoon.

The curriculum is kept relevant. The terms of the construction trade are taught, and the students are introduced to the hand and power tools that they will work with. Safety on the job is instilled from the beginning. Math relates to measuring of doors, windows, or other related areas, or to weighing this, that or the other. Reading is translated into the practical: "What mix of gravel, sand, and cement will produce the mortar needed?" "White wires are ground wires." When an on-the-job problem arises, the students can retire to the trailer with their teacher to study and solve it. The teaching means something; the learning is real and right now. . . .

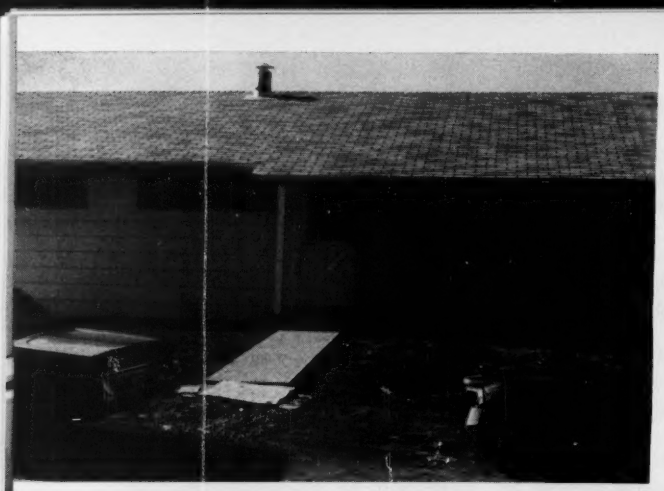
"In my estimation," says Alvin Sheetz, Director of Special Education of IU–1 and the project's guiding light, "These boys are proving that they can learn; they can accomplish. They are doing meaningful work that is a benefit not only to themselves but to the community as well. Many of them are succeeding for the first time. And they are succeeding in championship fashion!" In support of this, Ed Tekavec, IU–1's supervisor of special classes said, "This is what special education is all about. It should be flexible; it should meet the everyday needs of the students. We have gone beyond teaching a kid how to make a lamp or a stool and then saying to him: 'Ok, you're ready to go out into the world of work.' He wasn't ready when we used to say that, but he is ready now!"

Do the graduates of the Smock program fulfill in deed the things they have learned? Alvin Sheetz supplies the answer: "Of the eight graduates in the class of 1972, it is significant to emphasize that all eight are not employed in the building trades. Proper employment is our main concern and the Smock Project is but the vehicle to make employment a reality. The experiences at Smock amplify the opportunity to learn work habits, attitudes, develop skills, the use and care of tools and equipment, coordination, measurement, safety, and much more." Two graduates entered construction work and one each went to work for a lumber mill, a glass manufacturing plant, a coal mine, a power company, summer work and then the armed forces. The eighth student went directly into the armed forces. The students' hourly wage rate, at the time of this writing was from $2.60 to $4.80.

In The Beginning

The direction of IU–1's providing real work to its students had its beginnings in 1964 when an abandoned school bus garage was turned over to the unit as a classroom and training area. Not having been used for years, the garage bore the scars of years of neglect. A massive cleaning campaign dressed the old building in more respectable attire, but the picture it presented was still a sad one to behold. Complete renovation would be the only cure.

Alvin Sheetz describes that early work: "It was obvious that in getting the building ready to be occu-



Photos above show, at left, a newly constructed house. While, at right, a rehabilitated, formerly tax-delinquent house, makes a comfortable home for a low-income family. At left, IU–1 students carefully measure footing where a new home will soon be "on its way up." Students learn by doing and they do thousands of operations in the building trades.

pied some of the work could be done by students under supervision. From the onset . . . we marveled at the different types of work that the students could do. . . .

"The project took 2 years to construct a wood working shop, an auto shop, and one classroom. . . . The building had become more than a training facility to the students. It was a constant 'reminder' of what they could do. . . . We were convinced that it shouldn't end there."

And end it did not. In September 1967 a home that was about to be condemned in Connellsville (about 10 miles from Smock) was given over to the program. The students went "back to work." By September 1968 the 5-room home had had a complete facelifting. It became known as the Eliza Street School for trainable, high school aged girls. I visited the home and observed the creative things being taught these young ladies. Certainly, much of the learning atmosphere is derived from the pleasant surroundings. The girls contributed substantially to that atmosphere by producing such home decorations as hooked rugs, pillows, spreads, curtains, and drapes. The boys continue to be responsible for the maintenance of this building.

Commenting on the status of things in early 1970, Mr. Sheetz said: "The program was accomplishing rewarding gains in attitude and skills. . . . Continued success was vested in the development of occupational skills which the on-the-job experience provided. The program, however, had exhausted all the school needs for building and renovations." But, as luck would have it,

a new staff member of IU–1 just happened to be on the Board of Directors of Concerned of Pennsylvania. He saw the possibilities of a merger of interests and reported on it. The affiliation was consummated and it prospered.

Concerned People

CPI was incorporated as a nonprofit organization in July 1969. The underlying philosophy was formulated by a group of Protestant ministers and a Catholic priest: they wanted to do something constructive for the people of this depressed area. After consultations with many of the needy families in the area, they opened their membership to the community in order to make it truly representative of the area. The most critical need, they discovered, was adequate, low-cost housing. And so they became home builders.

In September, following incorporation, CPI conceived "Operation Rehab." The program had three main objectives: 1) assess the condition of county-owned delinquent tax property and, where practical, purchase and rehabilitate that property; 2) develop a training program using various manpower programs, volunteer action programs, and vocational technical training; and 3) sell the rehabilitated homes to low-income families through the Farmers Home Administration Interest Credit program.

Modest funding was obtained from State and local organizations. They struggled forward, but financial plight several times threatened to sink the organization. Nevertheless, with WIN and Neighborhood Youth Corps personnel the first two homes were renovated and sold for $5,000 each.

In January 1971 a cooperative arrangement between CPI and IU–1 was consummated. Under its terms CPI would provide the houses to be renovated or the lots upon which new houses would be built and the construction supplies needed for the jobs. CPI would also provide adequate compensation insurance on the students. It would be CPI's responsibility to sell the homes once they were completed. Further, CPI agreed not to demand completion scheduling dates, since the boys from IU–1 were in a training situation. In return, of course, IU–1 provides the manpower pool for the work to be done, but it retains its prime concern of teaching and developing skills.

The union was successful, mutually beneficial, and an asset to the community. It allows for "the most" from "the least": low-cost housing for the needy, community improvement, training for retarded youngsters, and some measure of economic relief for the area.

President of Concerned, the Reverend Graeme Sieber, epitomizes the organization's place in the community in these words: "We have become a success because of community acceptance and community support. Without this 'glue,' we certainly feel that we could not have done so very much."

The Message

And while the coal tipples of this area of the country continue to deteriorate, a new wealth is being extracted from the land and from its native sons. The wealth is, of course, community pride and the certain knowledge that destiny is in the hands of those who will mold it in the image of progress.

An editorial in the Brownsville *Telegraph* extolls many of the assets that this program has brought to the area. But it also points out what might be of far-reaching importance in "concept" rather than in "material" gains: "He [Mr. Alvin Sheetz] has shown taxpayers a big 'dividend' for their 'investment' in special education programs. These programs are far too often misunderstood. . . . Far too often considered to be waste by many taxpayers. . . . Hopefully the program developed by the IU–1's special education chief will show that such money was not wasted and there will now be an understanding of the goals of special education work."

But recognition is also accruing at a national level. Mr. Sheetz was recently presented an award of merit by the President's Committee on Mental Retardation for "outstanding effort on behalf of the mentally retarded." This was the first award of this nature made by the Committee. Further the President's Committee is determined to present this project as a model for replication throughout the country. Its officials feel that the principles demonstrated here could be imitated to advantage in many depressed areas in the Nation.

Mr. Sheetz believes that "the only significant difference between the mentally retarded and the 'normal' is *time*." He and IU–1 and CPI are helping to further shorten that time differential. ■

Project Reports

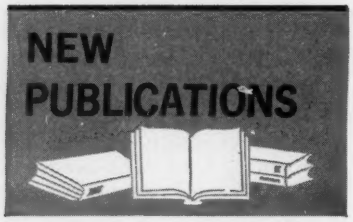
(*Continued from page 31*)

REGIONAL SPINAL CORD INJURY REHABILITATION CENTER. (RD 55279) Rancho Los Amigos Hospital, Inc., 7601 East Imperial Highway, Downey, Calif. 90242. 252 pages.

REHABILITATING THE CORONARY PATIENT FOR WORK. (RD 1994) Cardiopulmonary Rehabilitation, Montefiore Hospital and Medical Center, 111 East 210th St., New York, N.Y. 10467. 340 pages.

A COMPREHENSIVE STROKE REHABILITATION PROJECT IN SELECTED GENERAL HOSPITALS. (RD 55179) Chicago Heart Association, 22 West Madison St., Chicago, Ill. 60602. 90 pages.

SPECIAL VEHICLES FOR THE SEVERELY DISABLED. (RD 55267) Regents of the University of California, Campus Research Office, 250 Sproul Hall, University of California, Berkeley, Calif. 94720. 24 pages.



Riding For Rehabilitation. Joseph J. Bauer. Canadian Stage and Arts Publications Limited, 49 Wellington St., East., Ontario, Canada. 127 pages. $9.75.

In the first part of this book the author recounts how he overcame the painful consequences of various mishaps. It is his personal story and, also, that of a dedicated group who organized an equestrian program for handicapped adults and children. Finally, it is the story of how the book came to be written.

"A Guide For Handicapped Riders And Their Instructors" serves the dual purpose of the book's subtitle and title of Part II. In this section's 21 chapters, many aspects of riding are examined, aspects pertaining to riding generally and to handicapped riders specifically.

In addition, the chapters look into the peculiar aspects of riding for different disabilities. For example, it deals with riding for the blind, the deaf, and the physically handicapped and retarded children. It also looks into riding as preventive therapy.

Family Therapy: A Triadic-Based Approach. Gerald H. Zuk, Ph. D. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 289 pages. $12.95.

The procedures and goals demonstrated by a relatively new family therapy technique—the triadic-based method—are contrasted in this new publication with a more traditional approach to family psychoanalysis. When following this latter, more customary approach, the counselor remains basically an individual-oriented, objective overviewer who assumes that behavior can change as a result of directed insight. The triadic approach to family counseling, however, draws the therapist into an active, personal involvement in the bitter exchanges which occur during the therapy sessions. In this instance, therapeutic change arises out of the "mutual efforts of therapist and family to change each other."

In addition to examining the theories behind the triadic-based method the author illustrates how this therapy approach may be directed to specific family problem situations. Two detailed family interviews and discussions are included in the book in order to convey something about the therapist's working methods and his style of relating to the patients.

The book also explores general techniques of family therapy, specific challenges facing therapists today, and various disturbing patterns of family behavior which, if unresolved, could result in consequences threatening the integral whole of the family unit.

Placement and Followup in the Vocational Rehabilitation Process. Ninth Institute on Rehabilitation Services, RSA, 330 C St., S.W., Washington, D.C. 20201. 154 pages.

Of major concern to all vocational rehabiltation personnel is the satisfactory placement of rehabilitation clients. An indepth study of this challenging aspect of the rehabilitation process is reported in this new training guide. The document carefully examines placement and followup procedures: the services are thus brought into their proper perspective within the field of rehabilitation and their importance as a vital function of State and local agencies is effectively established.

The booklet focuses on placement concepts, quality innovations, and administrative, staff, counselor, and training considerations. Also developed, are useful recommendations and guidelines to assist counselors in providing their clients with the maximum benefit of the position placement, preclosure, and followup services.

Models and Functions of Counseling for Applied Settings and Rehabilitation Workers. Jerold D. Bozarth, Ph. D., editor. Arkansas Rehabilitation Research and Training Center, University of Arkansas, West Avenue Annex, 346 North West Ave., Fayetteville, Ark. 72701. 221 pages.

A collection of major articles dealing with the role, function, and practice of counseling in rehabilitation and other settings is presented in this book of informative readings. The text brings together both general and specific aspects of counseling; its basic purpose is to provide students and practicing counselors with guidance models and information dealing with the techniques, theories, influences, and motives set forth by the rehabilitation counseling profession.

The Role of Facilities in Training Rehabilitation Personnel: Abstracts of Conference Papers and Recommendations. James E. Trela, editor. Research Department, Vocational Guidance and Rehabilitation Services, 2239 East 55th St., Cleveland, Ohio 44103. 84 pages.

The abstracted papers and recommendations which make up this monograph were originally presented at a 3-day conference sponsored by Vocational Guidance and Rehabilitation Services in conjunction with RSA. The papers included in this publication clearly illustrate the basic designs of the conference namely, to examine the role of facilities in meeting expanding training needs and to formulate constructive recommendations that would lead to a strengthening of this role.

The complete conference papers, proceedings, and findings will be revised, edited, and printed at a later date.

Identification Of The Exceptional Rehabilitation Client

Joseph T. Kunce, Ph.D.
Corrine S. Cope Ph.D.
Douglas E. Miller
Nathan Lesowitz

Rehabilitation programs are increasingly serving a wider range of disabled and disadvantaged people. Some groups such as drug addicts, public offenders, public assistance recipients, and social security applicants have lower than average probability of achieving rehabilitation success.[1,2] The severely disabled also pose distinct challenges to the rehabilitation service delivery system. The development of improved means for identifying and classifying such exceptional clients should be useful in the modification, development, and improved management of rehabilitation services to better meet their unique problems.

Some of the ramifications of increasing services to the exceptional client can be realized from a recent survey on providing services to adults with chronic renal failure.[3] The medical expenses incurred in providing extended life-support services for such a client's lifetime could be greater than the average case service expenditures available to a single rehabilitation counselor for his entire caseload during a given year. Most counselors and State administrators, however, are obligated to provide services to as many clients as possible and still operate within the constraints of their budgetary allotments. Many, therefore, pragmatically resist the concept of "opening the door" of rehabilitation services to *all* individuals who are in dire need of medical services and who also may have uncertain potential for gainful employment.

The restriction of vocational rehabilitation services to those who have "a reasonable chance for vocational employment" has served as a way of concentrating available resources to a special kind of clientele. The substitution of broader social and humanitarian goals for the one of employment will require vastly greater rehabilitation resources in terms of finances and staff. Such a change implies provision of services to a wider range of clients and could take away resources for those clients for whom rehabilitation services have previously proven beneficial. Changes in program outcome goals may eventually require (1) a better means for identifying the "exceptional client," and (2) special authorizations for money and staff to work with this type of client.

Client characteristics, program services, and the *type* of rehabilitation outcome are all important factors to consider in determining what constitutes an exceptional client. The analysis of outcomes of special groups of clients according to diagnosis is one procedure that can be used to identify "at-risk" populations. An alternate procedure is to identify and isolate *specific* personal and social factors that relate to rehabilitation outcomes. This latter method can be modified to include combinations of charac-

Dr. Kunce is Project Director and Professor of Education, Regional Rehabilitation Research Institute (RRRI); Dr. Cope is Acting Director, Rehabilitation Counselor Training Program; and Mr. Miller is Research Associate, RRRI. All three are located at the University of Missouri, Columbia. Mr. Lesowitz is Chief, Statistical Analysis and Systems Branch, RSA.

teristics that predict rehabilitation outcomes. Our previous research [4,5] shows that such a method has considerable promise for identifying the exceptional rehabilitation client.

The procedure that we have developed for estimating "rehab feasibility" consists simply of identifying client characteristics that relate to general employment-hiring practices (e.g., prior education, work experience, age, etc.). Arbitrary scores are assigned to each of these selected variables. For example, the points assigned to elementary school education, some high school education, and high school graduation were respectively, 0, 1, and 2 points.

TABLE 1.—*Outcomes and Feasibility Scores for Seven State Rehabilitation Agencies*

Score	n	Percent of group:		
		Competitive employment	Salary $60 weekly or more	Rehab status "26"
20	29	93	97	90
18, 19	297	91	94	90
16, 17	986	84	84	88
14, 15	2,349	79	71	87
12, 13	5,340	69	56	82
10, 11	5,212	59	42	75
8, 9	2,950	51	34	71
6, 7	1,008	39	28	66
4, 5	253	28	13	62
0–3	49	20	10	45
Total	18,473	63	50	78

Similarly, points of 0, 1, and 2 were assigned to other factors, such as levels of previous weekly salary before rehabilitation, years of prior work experience, etc. The use of 10 variables in such a manner provided us with an index that yielded a "feasibility" score of 0 to 20 points for any one client depending upon his pattern of personal characteristics. Higher feasibility scores indicated a more favorable vocational outcome.

How can the exceptional client be identified from such scores? Table 1 shows the relationship between feasibility scores and the vocational outcomes of 18,473 rehabilitation clients provided services by seven midwest State agencies in 1968. The results showed that 93 percent of the clients having feasibility scores of 20 were placed into competitive employment, for those with scores of 18 or 19 the percentage was 91. In each successive lower category the percentages were 84, 79, 69, 59, 51, 39, 28, and 20. Similar trends were found for the other two outcome criteria: job salary and closure status "26" (client rehabilitated).

Using these data, the exceptional clients could be defined as those having feasibility scores of seven or less. For example, of the 1,008 that had scores of 6 or 7, only 39 percent found jobs in competitive employment situations and only 28 percent found jobs paying $60 or more a week. Altogether, of the 1,310 clients with scores 0 through 7, 36 percent got competitive jobs and 25 percent got jobs paying $60 or more weekly at closure from rehabilitation services.

Even though these exceptional clients had less than a 50–50 chance of obtaining a favorable vocational goal, it is important to note that the majority of them did benefit from rehabilitation services. Nearly two-thirds of the 1,310 clients had been terminated from rehabilitation services in a "26" closure status. This 26 status reflects improved adjustment and includes attainment of such outcomes as homemaking, sheltered workshop employment, etc., as well as competitive employment.

The relationship of the feasibility scores to outcomes for clients in six State agencies for the blind are presented in Table 2. For this group, clients with feasibility scores of 11 or less could be considered as exceptional rehabilitation clients. Specifically, of the 707 clients with scores of 11 or less, only 24 percent were placed into competitive jobs and 18 percent into jobs paying $60 or more a week. As with the exceptional client in the general caseload, the majority of these exceptional clients

TABLE 2.—*Outcomes and Feasibility Scores for Six State Agencies for the Blind*

Score	n	Percent of group:		
		Competitive employment	Salary $60 weekly or more	Rehab status "26"
20				
18, 19	*11	73	73	82
16, 17	49	82	90	88
14, 15	106	71	71	81
12, 13	226	54	45	82
10, 11	256	34	26	79
8, 9	249	25	19	74
6, 7	138	14	9	72
4, 5	56	7	4	79
0–3	*8	0	0	63
Total	1,099	38	30	78

*Percentages based on small numbers cannot be considered reliable.

benefitted from rehabilitation services since 76 percent of them had a "26" closure status.

According to national statistics, the rehabilitation outcomes of clients with blindness are similar to those of the average rehabilitation client. Nevertheless, experienced workers realize that clients with severe disabilities, such as blindness, may pose more rehabilitation problems than the average client. Comparison of the data in Table 2 with Table 1 shows that some of the rehabilitation outcomes are in fact less favorable for the blind with regards to competitive employment and to job salary. Fewer blind clients than general caseload clients (38 percent to 63 percent) found competitive work. Similarly, for salaries of $60 or more a week, the percentages were 30 and 50. The status 26 closure rate of 78 percent for both types of agencies in this study, therefore, does not adequately reflect differences in vocational outcomes.

These findings indicate that the severity of the physical disability is not necessarily a significant employment barrier if a client has numerous vocational assets in terms of previous education, employment stability, and so on. The rehabilitation outcomes of the blind clients and the general clients with feasibility scores of 12 or more points were similar with respect to job placement and salary (see Tables 1 and 2). However, blind clients with lower scores had substantially less favorable vocational outcomes than clients with similar scores from the general agencies.

Several modifications of the feasibility scale may be necessary. The development of separate norms for different disability groups is needed to identify more accurately the exceptional client. Furthermore, the refinement of the 10 variables selected for use in this index may make more precise predictions possible. Inclusion of additional psychological factors and social variables may also be useful.

In addition to identifying the exceptional client, research is needed to determine what patterns and types of client services are especially suited for such clients. With improved medical technology, counselor strategies, and service-delivery systems in the rehabilitation field, it may eventually be possible for more of the severely disabled, exceptional clients to achieve a greater degree of employment success.

The investigation of feasibility scores based on 10 personal characteristics of 18,473 rehab clients from seven general rehabilitation agencies and 1,099 from six agencies for the blind showed that about 10 percent of the clients in State programs at the time of referral had a low probability of achieving employment success in competitive situations. Such clients could be considered "exceptional."

Specific Findings and Implications are:

- Over one-half of the clients in agencies for the blind and 7 percent of the clients in the general rehab agencies could be considered exceptional.
- The percentage of clients determined "rehabilitated" by closure status "26" does not reflect the difficulties involved in the rehabilitation process and in the attainment of employment success. Such differences are more apparent from examination of specific criteria such as the type of employment and job salary.
- A client with a severe disability but with multiple vocational assets may have as favorable a prognosis as a client with a less severe disability but more vocational liabilities. A severe disability with limited vocational assets, however, connotes a highly unfavorable employment outcome.
- If an agency is evaluated primarily upon a cost-benefit type of appraisal, the provision of services to the more profoundly disabled may adversely affect their ratings unless some special allowances are made.
- One means for facilitating an agency's capability to help the profoundly disabled may be to provide special programs and authorizations for such exceptional clients. Specific goals of competitive employment would not be expected, although they might occur.
- The feasibility scores may be a useful tool in evaluating client difficulty. However, scores should *not* be used alone for apriori screening or limitation of rehab services to any one client.

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ACROSS THE DESK

COMMON COLD: The common cold is here to stay. The production of an effective vaccine is not likely to occur in the near future. Researchers state despairingly that there are just too many cold viruses around; the number of identifiable germs has now reached 113! Apparently our main hope of salvation lies in the development of antiviral drugs to stop the cold after it starts.

THE NEW YORK TIMES has opened its informative doors to the visually impaired reader. A large-type, weekly edition is available at a yearly rate of $35 to residents of the U.S. and $40 to people who live outside the U.S. The Times address is: 229 West 43rd Street, New York City 10036.

POLICE RECRUITS in Florida get an intensive 2-hour training course in the recognition and handling of mentally retarded persons. According to Mrs. Delores Norley, president of the Florida Association For Retarded Children, "Whether a youth even enters the maze of the legal process may have entirely to do with the policeman's knowledge of retardation and with his mental set resulting from a lifetime of either accepting or rejecting the myths which surround the subject of retardation."

Mr. Larry Bettis, a former client of the Nevada Division of Rehabilitation, has been appointed as Deputy Attorney General for the Department of Health, Welfare and Rehabilitation. Welcoming Mr. Bettis aboard was Mr. Roger Trounday, Director of the Department. Also present was Mr. John Lee, Division of Rehabilitation, who was Mr. Bettis' first counselor.

Mr. Bettis is a graduate of the University of Arizona Law School. As a victim of polio, he was certified for rehabilitation services in 1962 by Mr. Lee. "As a young man entering law school," Mr. Bettis explains "I was very grateful to have the services available by rehabilitation and the State. I don't know if I could have gone on to college without that assistance. I believe that the handicapped often have stronger desire to go forward, and if they can receive the encouragement and financial support they need, they will often excell."

WARNING: It has been determined that smoking lettuce-leaf cigarettes may be hazardous to your health!

This kind of notice might easily have accompanied a recent investigation which was carried out among heart patients in a Califirnia Veteran's hospital. The study, as reported in an article of an American Heart Association journal, concluded that even if a cigarette did not contain the slightest amount of nicotine, the delivery of oxygen to the heart muscles was still very much impaired.

Recipients of the Lasker Award for Distinguished International Service to the Handicapped, Dr. James Garrett, Mrs. Kamala Nimbkar of India, and Mr. Jean Regnier of Belgium. Pictured with the recipients (2nd from right) is Dr. Henry H. Kessler. The award was made in Australia at the XIIth World Congress of Rehabilitation International.

REHABILITATION RECORD

The weakest ink is better than the strongest memory

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